MENTAL HEALTH SERVICES IN CANADA

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PREFACE

This monograph was prepared at the request of the Department's Consultant in Mental Health, Dr. C.A. Roberts, for the Fifth International Congress on Mental Health which meets in Toronto in August of this year.

Data for this document were derived directly or indirectly from a variety of reports and correspondence received from the provinces. The initial draft of the report was reviewed by the provincial health officials. Dr. J. D. Griffin, General Director of the Canadian Mental Health Association, reviewed the preliminary draft and offered constructive suggestions. We wish to express our deep appreciation for the co-operation of both the governments and the individuals concerned.

Dr. Roberts' guidance and the assistance of his staff were of the greatest value throughout the course of preparation of the report. We also wish to acknowledge the contributions of the many others, not specifically mentioned, whose reports and documents were drawn on gratuitously. The research was carried out and the report written by the Health and Rehabilitation Services Section of the Research Division.

Joseph W. Willard,
Director, Research Division.

MENTAL HEALTH SERVICES IN CANADA

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MENTAL HEALTH SERVICES IN CANADA

INTRODUCTION

Mental illness is Canada's most serious health problem. Over 60,000 mentally ill and mentally defective persons are patients in institutions. Between 1948 and 1952 the caseload of the public mental hospitals showed an increase of well over 6,500 patients, while waiting lists failed to decrease significantly. It has been estimated that on any given date mental hospital patients account for almost one-half of all persons hospitalized in Canada, that they out-number patients in all public general hospitals and that in terms of lost time, mental illness exceeds the totals for tuberculosis, cancer and poliomyelitis combined.

The cost of operating these mental institutions has also risen during the postwar period. Increases in the number of patients, in prices and in the extent and quality of services provided have raised operating costs from $35,000,000 in 1948 to $60,000,000 in 1952. Nevertheless, the per diem cost per patient is lower than that of maintaining a prisoner in a federal penitentiary.

This grim picture presents only a part of the problem. The total does not include, either in terms of caseload or in terms of cost, the turnover of the seven psychiatric hospitals or of psychiatric in-patient departments of general hospitals. It does not include the thousands who, each year, seek aid as out-patients of hospitals or clinics; it does not include the children who receive help through child guidance services; it does not include those who seek assistance from private practitioners or, failing to seek help, become delinquents, alcoholics, drug addicts or suicides. Moreover, it does not include thousands who, because they lack knowledge or means or because they shun the stigma that the prejudiced centuries have attached to mental illness, fail to seek help until such time as they become long-term cases in a mental hospital.

No figures are available for these groups, nor can any price be set on wasted manpower, ruined lives and unhappy families. It has been variously estimated by informed sources both in Canada and the United States that one out of every ten persons living in those countries will at some time or other need assistance in facing his everyday problems.(1) If that help is

(1) The source cited here is the Annual Report of the General Director of the Canadian Mental Health Association, 1952, p. 1.

available and within his reach, more serious complications may be averted. Many will require institutional care, however. No estimate is available of the numbers who require hospitalization, for rates vary as treatment procedures change. However, according to the 1948 provincial health surveys long waiting lists testified to a considerable demand for accommodation beyond the numbers appearing on the hospital records.

As closely as it can be estimated at the present time, this is the scope of Canada's mental health problem. How long it will remain within the present limits is another question for a number of variables are involved. Of these, perhaps the major factor is the increasing life expectancy with its resultant growing demand for accommodation for seniles and mental defectives.

How is Canada attempting to solve its mental health problems? The question can be answered only by examining mental health services carefully and objectively, service by service. This is the purpose of the following report.

The report is divided into twelve major sections. Section II consists of a brief survey of the historical development of mental health services in Canada, beginning with the early nineteenth century. Workers in this field who become discouraged over the seeming lack of progress in limited areas need to view the present situation as a part of a greater whole. The major trends over the past century have been summarized at the end of the section.

Section III deals with legislation governing admission to mental institutions, appeals and discharge procedures. Mention is also made of legislation pertaining to specific classes of patients: the mentally defective, the epileptic and the mentally ill who are detained in jails or penitentiaries.

The general administration of mental health services is outlined, province by province, in Section IV. Historical trends are reflected in the gradual assumption of greater responsibility by provincial governments as clinical services were developed to supplement and extend the work of the hospitals.

Section V contains both a quantitative and qualitative analysis of institutional care for the mentally ill in Canada. Until recently, public mental health programs involved chiefly treatment and custodial care of

persons committed to mental institutions. Although the value of therapy was recognized, treatment frequently remained an ideal for the overcrowded conditions, the shortages of qualified personnel and the lack of adequate financial support often limited the hospital programs to custodial care. Overcrowding and recent measures to alleviate this condition are discussed in the subsection on hospital accommodation. This is followed by a description of the gradually expanding treatment facilities in the mental hospitals, as they exist today. The last subsection of this unit describes the seven psychiatric hospitals which provide intensive short-term therapy for cases with a favourable prognosis and, in numerical terms, the psychiatric units in general hospitals.

Following the discussion of hospital services for the mentally ill, Section VI gives an account of the more specialized facilities for certain classes of patients - the mental defective, the tuberculous mental patient, the epileptic, the alcoholic and the senile. Separate facilities for these groups are a twentieth century development. Although progress is being made, the process of segregation has been handicapped by the overcrowded hospital conditions and is, as yet, far from complete for most of these classes.

There is no clear-cut demarcation between prevention and treatment or between treatment and rehabilitation. What is treatment for a patient may well be prevention for members of his family. However, insofar as any distinction is possible, what may be considered prevention is carried on through community clinics and out-patient hospital departments throughout Canada. These services are described in Section VII.

Section VIII is concerned with mental health personnel. Down through the years, as the idea that mental institutions were places of treatment rather than custody became generally accepted, and later as intensive short-term therapy programs were established, the need for skilled personnel increased progressively. In Canada, supply has never kept pace with demand. Today, with the rapidly expanding hospital and clinical facilities, the need has become acute. To meet this need a vast training program is underway, financed largely by the federal government through a Professional Training Grant. The personnel situation, as it was in 1948 when the training program was launched and as it is today, forms the basis of discussion of this section.

Subsequent sections deal with other elements in Canada's mental health program. As in other countries, prejudice and ignorance concerning mental illness have constituted a formidable barrier to progress. To eliminate such prejudice, emphasis has been placed on public mental health education which today is a function not only of special agencies but of every mental health worker in the field. The first part of Section IX outlines the agencies and the educational media in use at the present time as well as efforts to evaluate the effectiveness of public education; the second part discusses the mental health services provided by the public school systems. Im most provinces they are limited, as yet, to opportunity classes for retarded children. Teachers are being trained to recognize incipient emotional disturbances, however, and children with emotional, personality or academic problems are referred to the nearest child guidance clinic or to other sources. The school medical unit assists with this work in many urban areas; elsewhere the public health nurse plays an important role as case-finder.

Most of the psychiatric hospitals in Canada and many of the community clinics assist the courts in cases where the accused pleads "insanity" or where mental disturbance is suspected. Services rendered to courts and reform institutions are described in Section X.

In Canada, research into mental health problems has just begun. Because of the difficulty of obtaining adequate support during past years relatively few studies were carried out at the universities. Following World War II, however, several federal agencies established grants for extramural research and investigations of both a fundamental and applied nature are now well underway. The growth of this program is discussed in Section XI.

The final pages of the report answers the question: who finances the mental health program in Canada? This section is divided into two parts describing numerically (a) the cost borne by the various government agencies and the cost to the patient, and (b) the part played by the federal government under the National Health Program.

HISTORICAL DEVELOPMENT OF MENTAL HEALTH SERVICES

The history of Canada's mental hospitals dates back to the early nineteenth century when the public became aware of the need for segregating the mentally ill from the criminal. The first separate accommodation for the mentally ill was provided in 1836 at Saint John, New Brunswick, when a small hospital, originally built for cholera victims, was appropriated as a shelter for the "insane poor" of that province. In 1847, New Brunswick passed an act establishing a provincial asylum(1) and a new institution - the beginnings of the present Provincial Hospital at Lancaster - was erected.

Public opinion was moving in the same direction in other provinces.(2) In Newfoundland, the earliest record of interest in the mentally ill was noted in 1836 when the Governor, during the course of an address to the House of Assembly, recommended that an additional wing be added to the General Hospital for the separate accommodation of lunatics.(3) No immediate action was taken, however, and it was not until 1845 that separate quarters were provided in Palk's Cottage; the patients from Palk's Cottage became the first residents of the new asylum opened for pauper lunatics in 1854.

In Prince Edward Island, the smallest in area of the Atlantic Provinces, a hospital for the insane was built by the province at Brighton Shore, Charlottetown, in 1845. Several decades later (1880), the nucleus of the present hospital emerged. It was established on the 120 acre Falconwood Farm, three miles from Charlottetown, and was designed to accommodate 140 patients.

Shortly before the mid-century, Miss Dorothea Dix who was touring the United States pleading the cause of better care for the mentally ill also visited Nova Scotia As a result of her memorial to the provincial legislature,

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(1) Although the terms "asylum", "insane", "lunatic" and "chronic" are no longer acceptable to most provinces, they are retained in this historical section because they were frequently incorporated in the names of the early hospitals and because they reflect the attitudes of former times.

(2) While reference is made to "provinces", it should be recalled that the date of confederation was not until some time later, 1867, and that Newfoundland did not become a Canadian province until 1949.

(3) The General Hospital was at that time located at Riverhead, St. John's.

Nova Scotia passed a statute in 1852 empowering the Governor-in-Council to select a site for a lunatic asylum and to erect a building. Construction was completed seven years later.

While the mentally ill were gradually being segregated from the criminal in the Atlantic provinces. progress was also being made in Quebec and Ontario - then known as Lower and Upper Canada. As early as 1801 the government of Lower Canada had assumed responsibility for the costs of maintaining the insane hospitalized in the general hospitals operated by religious orders in Quebec and Montreal. A commission had been appointed to administer the payments and to submit annual reports to the government. This commission, endorsed by private physicians, urged the establishment of a mental hospital. Miss Dorothea Dix, too, visited Quebec to meet legislators and to petition for better facilities. The increasing number of mental patients strengthened the cause and in 1845 the provincial government contracted with three physicians to treat patients in a provisional asylum at Beauport. Three years later the Quebec Lunatic Asylum was built on the present site of the St. Michel-Archange Hospital; in 1850, Beauport patients were transferred there.

Upper Canada enacted legislation authorizing the construction of an asylum for the reception of insane persons in 1839. Two years later separate quarters were set aside in the York Gaol, and in 1850 a provincial lunatic asylum was established.

These were the early beginnings which were destined to develop into a program of care for the mentally ill and defective in Canada. Emphasis was entirely on accommodation and many years were to pass before the concept of "care" was interpreted in a broader sense. Although the establishment of provincial institutions was a significant advance, nevertheless many of the mentally ill who were not looked after by relatives or friends continued to be housed in poorhouses or jails. The plight of cases requiring continued care was especially tragic. The poor, the orphaned, abandoned children, idiots, degenerates, the aged and the infirm were frequently crowded in among the psychotic with little regard for classification. It was not until the concepts of treatment and trainability had become recognized that efforts were directed toward segregation of the major classes of patients.

In 1865, New York State passed a law requiring that the chronic pauper insane discharged from the state

lunatic asylums but not recovered should be housed in an asylum constructed specifically for that purpose.(1) The growing population of chronic indigent cases in the state asylums presented an additional strong argument for some distinctive grouping. It was also felt that the cost of maintaining a separate institution might be defrayed in part through the efforts of patients capable of working.

In Canada, similar conditions focused attention on the need for more adequate and less costly care for long-term cases. In 1859, the Provincial Asylum in Toronto found it necessary to establish, under provincial management, branch asylums for "incurable" patients. Nova Scotia adopted a dichotomous classification "curable-incurable" as a practical distinction fairly early. In an address to the Nova Scotia Medical Society in 1878, the superintendent of the provincial mental institution indicated that acute insanity should be treated by the same standards as organic disease, amenable to therapy and that the places providing such treatment should be designated as hospitals while the term asylum should be reserved for institutions maintained for the "chronic and idiotic insane".(2) Accordingly, two systems of administrative control began to take shape in Nova Scotia, which today continues to operate one hospital for the acute mentally ill and a number of county homes for cases requiring continued care.

In most provinces, however, public opinion gradually shifted away from the idea of separate asylums known and designated as homes for the "incurable insane". A new institution at Mimico, Ontario, erected in 1890 specifically to house chronic patients transferred from the larger hospitals functioned for only a few years in that capacity. It was deemed more expedient to shelter both acute and continued care cases in the same institution, though not in the same building. Generally speaking, this practice has been followed through subsequent years and only a few provinces today maintain hospitals exclusive to long-term cases.

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(1) Hurd, H.M. The Institutional Care of the Insane in the United States and Canada. Baltimore: The Johns Hopkins Press, 1916, Vol. I, p. 148.

(2) Nova Scotia Medical Bulletin, Oct. 1953, recapitulating the minutes of a meeting of the Nova Scotia Medical Society of 1878.

Further measures gradually resulted in a more satisfactory grouping of chronic cases. For the more quiet patients, several systems were put into practice: the farm colony plan, the cottage plan and boarding-out homes. The largest farm colony was developed by the mental hospital at Essondale, British Columbia, which was established in 1907 on a thousand acre property. This plan included medical supervision and recreation supplemented by regular manual work on the farm and gardens. Today, such employment is considered important for its therapeutic value as well as from the older viewpoint of economical administration.

Toward the close of the nineteenth century, the introduction of more intensive medical therapy led to a need for special hospital facilities for acute cases with a favourable prognosis. Several Ontario institutions urged the construction of reception centres where acute cases might be treated apart from the long-term patients. Such reception centres began to appear around 1900. Many patients remained in them throughout their hospitalization periods, out of contact with those requiring continued care. Concurrently, a marked increase was noted in the percentage of discharges.(1)

One of the earliest - if not the earliest - reception centres was constructed at the Provincial Hospital at Brockville in 1894. This hospital consisted of an admission centre for acute cases and six cottages for continued care cases. A similar plan at The Ontario Hospital, Whitby, opened around 1916, provided for a reception or observation hospital with adjacent convalescent cottages for acute cases. Separate cottages were provided for long-term patients who did not require (or had ceased to require) special medical treatment. Each cottage system had its own infirmary for the physically incapacitated and its own dining facilities to ensure segregation of the two groups at all times. Within the broad dichotomy of acute versus chronic, further sub-groupings became recognized as desirable but remained impractical for various reasons for many years.

During the last half of the nineteenth century, medical knowledge and surgical skills increased rapidly and began to be applied to mental patients. The American Psychiatric Association sums up the general improvement:(2)

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(1) Hurd, H.M., Vol. IV, p. 161.

(2) American Psychiatric Association, One Hundred Years of American Psychiatry. New York: Columbia University Press, 1944, p. 297.

> Along with the development of good nursing care, physicians began to apply modern knowledge and techniques... The stethescope and the thermometer began to be used more freely, surgery had found its logical application to certain organic diseases occurring among the insane and more adequate dietary and hygienic conditions were instituted in the hospitals.

In the early mental hospitals, untrainable defectives mingled freely with the psychotic as they do to a less extent today. One of the first institutions for low grade mental defectives on this continent was opened at Orillia, Ontario, in 1876. On the whole, however, specialized care for the mentally defective has been one of the later developments in the history of Canadian mental hospitals. In most provinces no segregation of this group was planned originally and no real advance was made until the last two or three decades. The provincial training schools established in Alberta in 1923, in Nova Scotia in 1929, in British Columbia in 1931 and in Manitoba in 1934 were among the earliest. Since the advent of the National Health Program in 1948, the federal government has given greater financial support toward the construction of hospitals and training schools for defectives than toward any other type of mental hospital accommodation.(1)

Separate institutional facilities for specific classes of mental patients are still limited. The outlook has changed, however, as medical knowledge increased. Since 1915, a section of the Ontario Hospital at Woodstock has been maintained exclusively for epileptics and in 1939 the remaining part of the hospital was set aside for tuberculous mental patients. In Quebec, the Foyer Dieppe at St. Hilaire, the Hotel-Dieu-du-Sacre-Coeur in Quebec City and the Etablissement Notre-Dame at St-Charles-sur-Richelieu admit only epileptics. In addition to these separate institutions a number of public general hospitals provide wards or units where epileptics may receive either in or out-patient care.

Until recently, the policy of most provincial institutions was to accommodate the senile aged with other long-term patients. Departments of Welfare and public welfare agencies were largely responsible for providing physical care for seniles who were not in mental hospitals. A few provinces - notably British

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(1) See "Services for Mental Defectives", page 85.

Columbia and Alberta - have for some years separated seniles from other cases needing continued care, however, and hospitals in other provinces are now developing separate programs of care and separate accommodation.

All provinces now provide special quarters and services for tuberculous mental patients. In many institutions x-ray departments screen all admissions and make intermittent checks of other patients and hospital staff. While separate institutions are rare, hospital units within institutions are found in every province.(1)

The trend toward segregation of various classes of patients is further illustrated by the separation of the "criminal insane" from other psychotics. The Ontario Hospital at Penetanguishene has a separate building for this group; the Provincial Home at Colquitz, British Columbia, and the Bordeaux Hospital in Quebec admit only mentally ill prisoners. To date, no provincial hospital has been set aside entirely for alcoholics and drug addicts, but some have separate units for these patients.

A relatively new type of institution, developed since 1900, is the psychiatric hospital. Plans for the Toronto Psychiatric Hospital began to germinate around 1908 when the Ontario government appointed a Royal Commission to visit European hospitals, and, on the basis of observations there, to submit recommendations for the construction of a short-term, intensive treatment centre designed to serve the community and to give assistance with court cases. These recommendations were not implemented until 1921, however, and meanwhile the Winnipeg Psychopathic Hospital was opened in 1919, thus becoming the first of its kind in Canada. Today, seven psychiatric hospitals have been developed. Most of them are closely integrated with the training and research programs of the larger universities.

Another recent trend has been toward integrating mental health services with other community projects through developing psychiatric units in general hospitals, day-hospitals and out-patient departments as well as stationary and travelling clinics of various kinds. Efforts directed toward removing the stigma attached to mental illness through public education have also been intensified.

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(1) The separate hospital for tuberculous mental patients at Woodstock, Ontario, has already been mentioned. One Division of this institution is now maintained solely for tuberculous cases while the other Division is reserved for epileptics.

During the past hundred years, the gradually emerging conception of mental hospitals as places of treatment rather than custody has had many ramifications. A major implication was the prerequisite change in hospital personnel from untrained custodians to skilled medical staff. During the infant years of the mental institutions, inmates were cared for by untrained male and female attendants - a system which also prevailed in the general hospitals. With the advent of medical therapy, the need for skilled workers became imperative.

One of the first training schools for mental nurses in North America was established at Kingston, Ontario; its first class was graduated in 1890. The School for Nurses of the Nova Scotia Hospital graduated its first class in 1894. A little later, in 1900, the Falconwood Hospital, Prince Edward Island, opened a training school. Interestingly, this hospital's annual report for that year states "the result is that our women's wards are entirely free from restraint" and "our men's wards are also entirely free from restraint".(1) Other provincial training schools were also established around the turn of the century. In 1910, nursing schools of the Ontario Hospitals for the Insane were all merged under a central board of examiners and a standardized three year course was adopted. In western Canada the first class of nurses was graduated from the mental hospital at Brandon, Manitoba, in 1923

Since the early days when training courses were set up by the mental institutions, most of their nursing staffs have been mental hospital graduates. A relatively small number of registered nurses have worked in the mental health field, chiefly in a supervisory capacity and in the sick wards and operating rooms. Even at the present time, however, only 1,007 registered nurses are employed in all of Canada's mental institutions.(2)

The shortage of nursing personnel has been a crucial problem throughout the history of mental hospitals and the provinces have made various attempts to find a solution During the 1930's, the idea of affiliated training was implemented. Under this method, nurses-in-training in a number of general hospitals were

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(1) Quotation reported by the Prince Edward Island Department of Health and Welfare, May, 1954.

(2) Data for 1953; see "Mental Health Personnel" page 131, for details of numbers and training programs.

required to spend some months in mental institutions.(1) Another type of course is the four year combined training program. The Provincial Mental Hospital at Ponoka, Alberta, provides an example of this type. In 1934 it introduced a combined general and psychiatric nursing course with two years of training in each field. Among later developments have been the introduction of post-graduate courses in the mental hospital schools, open to graduates of general hospitals, and advanced training at the university Schools of Nursing.

Despite the addition of some psychiatric nursing experience to the general hospital training programs, the shortage of nursing personnel persisted. As a result, a few years ago the mental institutions in Saskatchewan, British Columbia and one institution in Alberta launched a comprehensive training program entirely within their own hospitals. Initially, the training of psychiatric nurses within the mental hospitals was tried merely on an experimental basis and courses in the three provinces were not uniform. However, results of the experiment were satisfactory and the training courses were established permanently.(2) The psychiatric nurses organized their own professional groups in the three provinces and in 1950 formed the Canadian Council of Psychiatric Nurses, comprised of members of the three provincial associations. Work is now in progress to standardize the training and to define the terms "psychiatric nurse", "psychiatric nursing aide" and "certified nurse" on a nationwide basis.

From the earliest days of mental institutions, patients have been employed around the hospital premises, performing such tasks as laundry, kitchen work, gardening and farm work. Although the purpose of these duties was primarily economic rather than therapeutic, patients who were capable of manual work doubtless profited by them. For a large number of patients who lacked sustained interest in any type of activity, however, there was need for an organized program of occupational therapy. To direct such a program trained personnel were required to supervise activities suited to the needs of individual patients. Out of this need developed a new specialty - occupational therapy.(3)

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(1) The time spent in a mental hospital varied from one to three months.

(2) For further discussion on training see section "Mental Health Personnel".

(3) The Research Division is indebted to Mrs. L.C. Smith, Executive Consultant and Secretary of the Canadian Association of Occupational Therapy, and to Miss Margaret Langley, Dept. of Health, Toronto, for the early history of occupational therapy.

Occupational therapy was first established under the Department of Soldiers' Civil Re-Establishment at the time of World War I. Interestingly, the first course for occupational therapists (then called ward-aides) was initiated by the Faculty of Applied Science and Engineering, University of Toronto, which appointed a Vocational Officer for Ontario. A six weeks' course was established and most of the students accepted were former V.A.D.'s. There were no prerequisites based on either academic standing, age or experience. Three hundred of these "aides" were trained and placed in Veterans' Hospitals across Canada. Doctors became interested in their work and came forward to promote the organization of an official occupational therapy body. The first organization was the Ontario Society of Occupational Therapy. Branches were founded in some of the larger cities and the "ward-aides", as they were released from military hospitals, began to establish occupational therapy departments in hospitals caring for civilian patients.

By 1925, as the ranks had been thinned considerably by matrimony, and as demand exceeded supply, the University of Toronto was requested to set up a two year course on a permanent basis. At this time, too, the province expressed a demand for large numbers of occupational therapists for the mental hospitals. Accordingly, a two year training course with junior matriculation entrance requirements was established by the university's Department of University Extension. Since that time, though training facilities have been extended and courses have undergone various changes, occupational therapists have been employed as a necessary part of the mental hospital staffs across Canada. The demand for such therapy is evidenced by the recent initiation of a course for occupational therapy assistants. The first course of this kind was opened at the Ontario Hospital, Kingston, in January, 1953, with an enrolment of 18 students.

While these changes in medical care were being introduced in mental hospitals across Canada, the relationships of social and environmental factors to mental illness were being studied by the Social Sciences. As a result of their findings, social work departments have become an integral part of mental institutions, facilitating the collection of case histories and assisting discharged patients through the rehabilitation period. One of the first social service departments in a Canadian mental hospital was organized in 1931 at the Provincial Mental Hospital at Essondale, British Columbia.(1)

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(1) A social worker had been employed a year earlier, in 1930.

The recognition of environmental influences on mental health brought other changes for mental health services moved into the community. About the same time as social workers began to share in the work of the mental hospital, child guidance clinics were established in many of the larger communities. At Essondale, mentioned above, the newly employed hospital social worker carried on her duties in close collaboration with the provincial child guidance clinic in Vancouver; in outlying districts, welfare investigations were often carried out in co-operation with local social welfare staff and public health nurses. Ontario hospitals first utilized the services of the community welfare workers, made available through local agencies. This trend toward developing mental health services in the community has become more and more prominent and is one of the features of the present mental health program.

About this time psychologists also entered the mental hospital field. There is no record of the precise date on which the first psychologist was employed by a clinic or hospital, but evidence suggests the late 1920's, for several reported psychologists on staff by 1930.

Many of the new Child Guidance Clinics were sponsored by local school boards, thus bringing education into the mental health field. Clinical services soon expanded into the area of remedial work and speech therapists, teachers of remedial reading and other auxiliary personnel began to be employed. These personnel became especially useful in the training of the higher-grade mental defectives.

Among the latest additions to hospital staffs have been the recreational therapists and the various types of laboratory technicians. The employment of technicians has paralleled advances in medical knowledge insofar as hospital finances have permitted. Highly specialized medical and surgical personnel as well as technicians have joined the staffs of the larger hospitals or serve as consultants to the smaller institutions and clinics.

Perhaps the only voluntary organization which has had any great impact on progress in the mental health field in Canada over the last three or four decades is the Canadian Mental Health Association. Founded in 1918 and incorporated in 1926 under the title "The Canadian National Committee for Mental Hygiene", this voluntary group of interested professional and lay workers defined its purpose as follows:(1)

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(1) Shea, Albert A. (Ed.) Corporate Giving in Canada. Toronto: Clarke, Irwin and Company, Limited, 1953, p. 94.

> To work for the conservation of mental health, improvement in the care and treatment of those suffering from nervous and mental diseases or mental deficiency, and prevention of these disorders; to conduct or supervise surveys; to co-operate with other agencies concerned with this problem and enlist the aid of the Dominion and Provincial Governments; to help organize Provincial and local societies or committees for Mental Hygiene.

A national office was established in Toronto and branches were organized in several provinces. Its contributions covered a wide range of activities, including subsidization of research in universities, conducting the first surveys which led to the establishment of special classes for retarded children (Ontario, 1918-23), training teachers in mental health work, establishing parent-education classes, serving as a consultation bureau to a variety of industries and individuals, furnishing assistance in organizing personnel selection within the armed services during World War II, serving as a founding member of the World Federation for Mental Health, and co-operating with the World Health Organization, UNESCO, and other United Nations agencies. In 1954 it is the chief sponsor of the Fifth International Congress of Mental Health.(1) While the degree of its influence on developments in the mental health field cannot be appraised, it is safe to say that this voluntary organization, on its limited budget, has been directly or indirectly involved in most of the progressive steps made since its inception in 1918.

Mental health has always been a responsibility of the provinces in Canada. As already indicated, mental institutions had been built long before 1867, the date of Confederation. Following Confederation the provinces continued to bear most of the financial and administrative burden of caring for the mentally ill and mentally defective. They continue to do so today (1954). Changes in the nature and scope of mental health services have demanded changes in provincial administration, however. As services expanded, provincial departments of health took over the administration of mental institutions and

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(1) The scope of this voluntary association's activities are too broad to cover here. A complete review of its work was compiled under the title "Milestones in the History of the Canadian Mental Health Association," in 1950. It is distributed by the national office, 111 St. George Street, Toronto.

of other services, as they came into existence. These duties were assumed by the health departments in Alberta in 1921, Manitoba in 1928, Ontario in 1930, Saskatchewan in 1931, New Brunswick in 1936, Quebec in 1936, Prince Edward Island in 1946 and Nova Scotia in 1947. In British Columbia, the Director of Mental Health Services continues to be responsible to the Department of the Provincial Secretary, while in Newfoundland the provincial mental institution at St. John's carries out the major functions related to the provision of mental health services.

The federal government played no active role in providing services or care for mentally ill or mentally defective Canadians until after World War II. Prior to the war, the federal government had exercised control over immigration, had financed the cost of accommodation and treatment for Indians and Eskimos, who were cared for in the provincial hospitals and had provided services for war veterans.

World War II not only increased the volume of care needed for war veterans, but, through the system of screening recruits, brought the problem of mental health into sharp relief both in Canada and the United States for the neuro-psychiatric rejection rate was higher during World War II than during the first World War.(1)

Accordingly, when the federal Department of National Health and Welfare was organized, plans were made for greater participation in providing mental health services. On recommendation of the Dominion Council of Health, a separate Mental Health Division was set up within the department, and plans were made to assist the provinces financially under the proposed National Health Program. A National Advisory Committee on Mental Health was set up and federal plans implemented in 1948 as a part of the National Health Program.

Historical Trends

From a long-range viewpoint a number of trends in the development of mental health services became apparent. With some overlapping, they are summarized here in chronological order:

1. Separation of the mentally ill and defective from other persons in custody for criminal or civil offence.

(1) Menninger, W.C., Psychiatry in a Troubled World, N.Y.: The MacMillan Co., 1948, p. 347.

2. A gradual change from custodial to therapeutic care.

3. A separation of acute from continued care cases either in separate institutions or within an institution.

4. An incipient segregation of various classes of mentally ill and of trainable mental defectives either in separate institutions or within an institution, and a separation of chronic mental cases from welfare cases.

5. A change in the types of personnel employed, the degree of specialization increasing with the advances in scientific knowledge.

6. An incipient change in public attitudes toward the mentally ill, and an emerging interest in their welfare, evidenced by the formation of voluntary organizations.

7. A recognition that mental health services were a health problem, evidenced by the transfer of institutional administration to provincial mental health divisions.

8. A gradual shift in emphasis in the direction of community services, including not only educational media, diagnostic and short-term treatment services but the institutions themselves.

9. Increasing participation by the federal government, acting in a consultative capacity and assisting through the provision of limited financial aid.

10. A beginning of research into mental health problems.

LEGISLATION GOVERNING HOSPITALIZATION OF THE MENTALLY ILL

The last half century has witnessed a number of important changes in provincial laws dealing with hospitalization of the mentally ill. Many of the provinces have introduced modern terminology and in all but one or two, such words as "insane", "lunatic", "feeble-minded" and "idiot" have disappeared from the statutes. A recognition that medical diagnosis is the essential factor in establishing a condition of mental illness has led to the modification of legal procedures governing the admission of patients to mental hospitals, and whereas formerly the alleged mentally ill were usually apprehended and committed by court order, they are now generally admitted solely on medical certification.(1) An increasing awareness that mental institutions are places for treatment is reflected in the adoption, by all provinces, of legal measures providing for voluntary admission. Another important legal change in recent years is the establishment of a new category - the temporary patient. In several provinces the law permits a patient to enter a mental hospital or clinic for observation, diagnosis or short-term treatment without being formally certified as mentally ill and hence subject to an indeterminate period of hospitalization.

Prior to these developments, laws governing the commitment of patients reflected society's traditional attitudes toward the mentally ill; the major concern was to protect the public against "dangerous lunatics". Traditional laws were enacted mainly to secure and to maintain the safe custody of such individuals and when admission could not be obtained to an institution, confinement in jail was specified.

As mental derangement became recognized medically as a form of illness, institutions gradually ceased to function solely as places of custody and the inmates were considered as patients in need of treatment. This changing approach is reflected in the statutes. One of the initial steps in formalizing the change from an "asylum" to a "hospital" viewpoint was taken by the British Columbia legislature in 1897 when the "Insane Asylum Act" was revoked and replaced by the "Hospitals for the Insane Act". Legislation introducing the concept "hospital" was enacted in New Brunswick in 1904; Ontario

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(1) Three provinces combine judicial procedure with medical certification.

formally replaced "lunatic asylum" with "hospital for the insane" in 1907; Manitoba adopted the new designation in 1910; and in 1912 British Columbia substituted "mental hospital" for "lunatic asylum".

During the early 1900's the legally established requirements for admission to mental hospitals consisted of a court order supported by medical certification. Gradually the use of court warrant was abolished except for dangerous cases. Nova Scotia (1904) appears to have been one of the first provinces to sanction admission by medical certification alone. By 1916, voluntary admissions had become statutory in two provinces.(1)

Significant statutory revisions made in Ontario in 1935 established a pattern for recent progress. Simpler and more direct admission was authorized and a procedure introduced under which magistrates might demand a person to a mental hospital for an observation period not exceeding 60 days in order that his mental status might be diagnosed. The terms "insane and dangerous to be at large" and "idiot" were replaced by "mentally ill" and "mentally defective". In addition, provisions were made for admitting persons addicted to drugs or alcohol.

In New Brunswick and Saskatchewan, another important amendment concerning the withdrawal of legal committal by magistrate has been put into effect. In Saskatchewan, judicial action may now apply only in cases where an offence has been committed or where the alleged mentally ill person refuses medical examination. In both instances, the judge's authority is limited to authorizing admission for observation.

Methods of Admission of the Mentally Ill

The five principal methods of admitting patients to mental institutions are (a) voluntary admission, (b) admission by medical certificate, (c) admission by court warrant, (d) admission for observation purposes, and (e) admission of prisoners by Lieutenant-Governor's order. Table I summarizes admission methods applicable in each of the ten provinces. In Ontario, Saskatchewan, New Brunswick and British Columbia, mental defectives are admitted under the same general terms as the mentally ill. The five admission methods will be discussed in the order listed above.

(1) Hurd, H.M. (Ed.) The Institutional Care of the Insane in the United States and Canada. Baltimore: The Johns Hopkins Press, 1916. Vol. IV, p. 427.

Voluntary Admissions. All provinces provide for voluntary admission. In six provinces - British Columbia, Saskatchewan, Ontario, New Brunswick, Prince Edward Island and Newfoundland - the requirements are very similar: an individual desirous of hospitalization must be competent to apply in writing and the application must be endorsed by a medical practitioner. In the other four provinces, one or both of these conditions may be required. Patients admitted voluntarily may not be detained after giving notice of their wish to leave the hospital. If the mental status of a voluntary patient is such that an indeterminate period of hospitalization is required, a formal commitment procedure is prescribed.

An upward trend in the number of voluntary admissions appears in recent years. This is indicated in Table II. Of the 11,696 first admissions of 1952 for which data concerning method of commitment are available, 1,415 cases or roughly 12 percent were admitted voluntarily. Comparing 1952 with the immediate post-war years, the rate of voluntary admissions has practically doubled.

Admission by Medical Certificate. All provinces have statutory provisions authorizing admission by medical certificate, but three provinces require a judicial order to confirm the medical evidence.(1) The examination of the mentally ill person is entrusted to two qualified physicians, each required by law to examine the patient and to formulate a medical opinion independent of the second examiner.(2)

Admission by medical certificate has been the most common form of commitment for many years. Of all reported first admission in 1932, about 74 percent were made by this method;(3) twenty years later 75.9 percent were committed by medical certification. Thus, the proportions have remained almost unchanged.(4)

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(1) The three provinces are Alberta, British Columbia and Newfoundland.

(2) In the province of Quebec, only one qualified physician is required.

(3) This represents about 80 percent of all first admissions to mental hospitals in Canada during 1952. See D.B.S. Report on Mental Institutions, 1952.

(4) See Table IIB for the period 1946 to 1952.

TABLE I. LEGAL PROVISIONS GOVERNING ADMISSION AND COMMITMENT OF THE MENTALLY ILL, BY PROVINCE, 1953

Prov.	Voluntary Admission		Commitment Procedure							
					By court warrant as authorized by			By warrant of Lt. Gov. Council	Admission for observation	
	With medical cert.	Without medical cert.	By medical cert.	By judge's order and medical cert.	Attorney Gen.	Deputy Minister	Judge Magistrate or J.P.		By court order	Without court hearing
B.C.	X			X				X	X	X(1)
Alta.		X		X	X					X(2)
Sask.	X		X					X	X	
Man.		X	X				X	X		X
Ont.	X		X			X		X	X	X(3)
Que.	X		X			X(4)		X		
N.B.	X		X					X	X	X(5)
N.S.		X	X				X			
P.E.I.	X		X							
Nfld.	X			X		X		X		

(1) Admission under the Clinics of Psychological Medicine Act.
(2) Admission by order of the Minister of Health or upon medical certification.
(3) Admission through examination units.
(4) Admission authorized by the Minister of Health.
(5) Admission by Medical certification.

Admission by Court Warrant. Admission by court warrant applies whenever it becomes necessary to apprehend persons considered mentally ill and dangerous. A hearing is given before a judicial officer who is authorized to summon witnesses and to call for a medical examination by one or two practitioners. Methods of disposing of the case differ according to various provincial statutes. However, the judge is usually empowered to order detention in a mental hospital or to authorize temporary admission for observation purposes.

The use of admission by court order has declined in recent years. In 1952, court orders comprised 10.5 percent of the total reported first admissions to mental hospitals; during the early 1930's, records indicate 18 to 19 percent.

Admission for Observation. In several provinces, the statutes designate special clinics or psychiatric units as centres for short-term therapy for patient in need of observation or temporary care. The Crease Clinic of Psychological Medicine in British Columbia, the Toronto Psychiatric Hospital and other centres designated as "examination units" in Ontario and the psychiatric wards in general hospitals in Alberta are authorized by statute to provide such services. In general, admission requirements are less formal than for committal to a mental hospital; patients may apply for treatment voluntarily or they may be certified by a medical practitioner. A maximum period of detention, varying from thirty days to four months, is fixed by provincial statute.

In three provinces - Ontario, Saskatchewan and New Brunswick - temporary observation in a mental institution or clinic may be ordered by a court whenever a magistrate is of the opinion that the person charged with an offence requires a mental examination. Prior to the expiration of the observation period, the hospital or clinic superintendent must report to the court concerning the offender's mental condition.

Admission Procedure for Persons in Custody, Charged with an Offence. All provinces except Alberta, Nova Scotia and Prince Edward Island provide for institutionalization of a mentally ill prisoner who is in custody for an offence under a provincial statute. The order for such transfer is given by the Lt.-Governor in Council in three provinces (British Columbia,

TABLE II. TOTAL ADMISSIONS TO MENTAL INSTITUTIONS: BY METHOD OF COMMITMENT, 1946-1952

Year	First Admissions					Readmissions					Total				
	Certificate	Voluntary	Warrant	Miscell.	Total	Certificate	Voluntary	Warrant	Miscell.	Total	Certificate	Voluntary	Warrant	Miscell.	Total
							A. Number								
1946	6,871	496	1,059	11	8,437	1,873	280	385	4	2,542	8,744	776	1,444	15	10,979
1947	7,044	419	982	43	8,488	2,002	297	368	9	2,676	9,046	716	1,350	52	11,164
1948	6,759	530	1,027	541	8,857	1,937	363	341	199	2,840	8,696	893	1,368	740	11,697
1949	6,848	819	1,097	596	9,360	2,093	486	316	164	3,079	8,941	1,305	1,413	780	12,439
1950	7,792	999	1,090	135	10,016	2,422	641	396	28	3,487	10,214	1,640	1,486	163	13,503
1951	8,313	1,255	1,139	185	10,892	2,509	590	405	68	3,572	10,822	1,845	1,544	253	14,464
1952	8,879	1,415	1,202	200	11,696	2,847	757	473	85	4,162	11,726	2,172	1,675	285	15,858
							B. Percentage								
1946	81.4	5.9	12.6	0.1	100.0	73.7	11.0	15.1	0.2	100.0	79.6	7.1	13.2	0.1	100.0
1947	83.0	4.9	11.6	0.5	100.0	74.8	11.1	13.8	0.3	100.0	81.0	6.4	12.1	0.5	100.0
1948	76.3	6.0	11.6	6.1	100.0	68.2	12.8	12.0	7.0	100.0	74.3	7.6	11.7	6.3	100.0
1949	73.2	8.7	11.7	4.4	100.0	68.0	15.8	10.3	6.0	100.0	71.9	10.5	11.4	6.2	100.0
1950	77.8	10.0	10.9	1.1	100.0	69.5	18.4	11.4	(1)	100.0	75.6	12.2	11.0	1.0	100.0
1951	76.3	11.5	10.5	1.5	100.0	70.2	16.5	11.3	2.0	100.0	74.8	12.7	10.7	1.4	100.0
1952	75.9	12.1	10.3	1.7	100.0	68.4	18.2	11.4	1.9	100.0	74.0	13.7	10.5	1.2	100.0

(1) Less than 0.1 percent

Source: D.B.S. Annual Reports of Mental Institutions 1946-1952.

Saskatchewan and Ontario), and in four others by a specified Minister of the Legislature (Manitoba, Quebec, New Brunswick and Newfoundland). Medical certification regarding the prisoner's mental condition is prerequisite to the issue of a removal warrant in British Columbia, Manitoba, Quebec and Newfoundland.

Admission Procedures for Special Classes of Mental Conditions

Mental Defectives. In the provinces of Ontario, Saskatchewan and New Brunswick, mentally defective patients are admitted in the same way as the mentally ill (see Table I, p. 22); mental defectives cannot make voluntary application, however, and certain changes in terminology have therefore been made in the separate admission forms. In British Columbia, a separate Act governing the mentally defective was passed in 1953; under this Act, mental defectives are admitted by the same methods as the mentally ill, except that voluntary admissions are not permitted.

Under the separate Acts governing mental defectives in Alberta and Manitoba, the general principles underlying admission apply the same as in the case of the mentally ill -- i.e., the presentation of medical evidence and judicial hearing. However, other factors pertinent to the welfare of the mentally defective have been emphasized, especially in the Mental Deficiency Act of Manitoba where the written consent of the parent or guardian is required in both judicial and non-judicial proceedings. Both the Mental Deficiency Act of Manitoba and the Mental Defectives Act of Alberta contain provisions which permit the filing of an application for the release of mental defectives from institutions to the custody of parents or guardians within a specified date of such request. The consent of the Medical Superintendent (Alberta) or the provincial psychiatrist (Manitoba) is sufficient to implement this release in cases where no court proceedings were involved in the admission order.

Legal proceedings for the examination and care of mentally defective children in Nova Scotia are covered by the Children's Protection Act of 1950. In this Act, a "child" is defined as "a boy or girl actually or apparently under the age of eighteen years". This is the only physical age limitation for admission to an institution in any of the provincial statutes concerned.

A significant provision made in both Nova Scotia and Manitoba legislation is the requirement that an examination of a person, allegedly defective, must be

made by a qualified psychiatrist. However, in Nova Scotia this requirement applies only to admissions to the Nova Scotia Training School(1) and the Manitoba statute provides the alternative that the examination may be conducted by an approved medical practitioner.

In Quebec and Newfoundland, no statutory provisions apply exclusively to mental defectives.

Epileptics. In the provinces of Ontario and Saskatchewan, the laws relating to the mentally ill apply "mutatis mutandis" to epileptics. No provisions specifically authorizing the admission of epileptics are given in other provincial statutes. In the acts of Nova Scotia and Prince Edward Island, epileptics are mentioned only as a class of patients which the superintendent of a mental hospital may refuse to admit.

Alcoholic and Drug Habitues. The statutes of Saskatchewan, Ontario and New Brunswick contain provisions relating specifically to alcoholics and drug addicts. Newfoundland has made similar legislative provisions, but they apply only to alcoholic habitues. British Columbia, by statutory amendment in 1953, authorized the voluntary admission of alcoholics but regulations under this Act limit the number which may be hospitalized at any one time to twenty-five.

There are three authorized methods of admission: (a) by voluntary application accompanied by Medical Certificate, whereby a person may be detained for a period not exceeding one year, (b) by court order under which a person can be committed for a two-year period upon evidence that he is so given to the use of drug or alcohol as to be incapable of managing his affairs and is in danger of ruining his health and home, and (c) by medical certificate in the case of a person so affected as to require immediate hospital care. Detention in the last instance is for a specified period up to sixty days.

Habitues may be discharged from a hospital at the discretion of the medical superintendent in Saskatchewan, Ontario, New Brunswick and Newfoundland. In British Columbia, alcoholics admitted voluntarily may be discharged after 30 days' residence upon fulfilling the prerequisites for release required for any mentally ill patient.

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(1) In Nova Scotia adult mental defectives may be committed to a county hospital by two physicians, as in the case of the mentally ill.

Appeal of Committal

To allay the anxiety or the criticism of patients forced into institutions or detained for any length of time, five provinces have provided for appeal of commitment. Through an amendment passed in 1940, a patient in British Columbia is entitled to ask for re-examination by a special medical panel. In Alberta, a commitment may be appealed if the notice of appeal is given before the order for removal to hospital is issued. In Saskatchewan, the hearing of an appeal may require an examination before two psychiatrists. In Manitoba, an affidavit declaring that the patient is not mentally unsound and has been detained against his will may be served on the hospital superintendent and an examination of the patient may be carried out by two qualified physicians selected and paid by the applicant. A report of the examination must then be made to the Minister of Health and Public Welfare who may order discharge or direct further examination by physicians specially qualified to diagnose and treat mental diseases. The costs of appeal are borne by the applicant in Alberta and Manitoba. In Newfoundland, any patient committed to the Hospital for Mental and Nervous Diseases can appeal or have his case assessed by the Lunacy Commission set up by the government. The Commission checks the validity of all admissions and in cases of doubt can order re-examination by two selected physicians.

Discharge Procedures

At the discretion of the hospital superintendent, a patient in a mental hospital may be discharged unconditionally or may be committed to the care or custody of a relative or friend for a trial period. During the probation period, the ex-patient remains indirectly under the control of the hospital superintendent who is required to check regularly on his condition.

In Nova Scotia, the probation period may extend over three months; in the four western provinces(1), Newfoundland and Ontario, for six months. In New Brunswick, the hospital has authority to order an ex-patient's return within twelve months of his discharge from an institution. In Quebec and Prince Edward Island, the duration of a probation period is not fixed by law but is left to the discretion of the hospital superintendent.

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(1) In Saskatchewan, according to 1953 legislation, the probation period was extended to 12 months for the mentally defective.

Sterilization Laws

Two of the Canadian provinces make statutory provision for sexual sterilization of the mentally ill. The Sexual Sterilization Act of Alberta became effective in 1928. During the period from 1929 to 1950 inclusive, 2,675 cases passed before the Eugenics Board of Alberta and 1,242 operations were performed. In British Columbia, the number of operations was much smaller due to certain legal and other restrictions. Data presented in a survey of the mental hospitals of British Columbia in 1938, indicate that about fifteen operations were performed yearly. Most of the operations - usually performed at a neighbouring general hospital - involved female mental patients.

Laws Governing Trial and Custody of the Mentally Ill

Legal procedures governing prisoners or persons in custody who are adjudged to be insane are authorized under the Criminal Code (R.S.C. 1927, c 36), the Penitentiaries Act (R.S.C. 1953, c. 206) and the provincial Mental Hospitals Acts. Certain provisions of the Criminal Code dealing with the mental examination of an accused during trial are also relevant. These provisions are summarized below.

Question of Insanity During Trial. If, during the trial of a person charged with an indictable offence, evidence suggests that such person was insane at the time the offence was committed, then, if the person is acquitted, the jury must declare whether or not he was acquitted on the grounds of insanity. If, at any time after indictment but before the verdict is given, it appears to the court that the accused may be incapable of conducting his defence, then the court may direct that a plea of insanity be tried in order to determine whether or not the accused is fit to stand trial. If he is determined fit, the trial proceeds; if determined unfit because of insanity, the person is placed in custody to await the Lieutenant-Governor's order for removal to a mental hospital.

Mentally Ill Prisoners. Under the Criminal Code, the Lieutenant-Governor of a province is authorized to order the removal to a place of safekeeping of any insane person in custody in a prison, but not in a penitentiary. Provincial legislation similarly provides for the removal of a mentally ill prisoner in custody for an offence under a provincial statute. In four of the seven provinces which have made legal provision for

the removal of mentally ill prisoners from provincial gaols to mental institutions, medical certification is a prerequisite.(1)

The disposition of prisoners who are found to be mentally ill after entering a penitentiary is dealt with under the Penitentiaries Act. If, within three months from the time a prisoner enters a penitentiary, it is established by medical certification or otherwise that the prisoner is "insane or imbecile" or was "insane or imbecile" at the time of entry into the penitentiary, then he may be returned to the place of confinement from which he came.(2) In such cases further responsibility for the individual rests with the provinces. Furthermore, it is provided that if a prisoner serving sentence in a penitentiary is medically certified as insane, then he may be transferred to a provincial asylum if an arrangement for the maintenance of mentally ill prisoners exists between the penitentiary and the province.(3) An insane convict who has remained in prison until the expiration of his sentence may be removed by order of the Lieutenant-Governor to a place of safekeeping within the province.(4)

Despite the provinces' primary responsibility for providing mental hospital accommodation for insane prisoners, implicit in the Penitentiaries' Act, the requirements are not fully clarified so as to bind the provinces to a definite procedure. Cases are reported where, due to the over-crowding of hospitals or to other conditions, provinces have not felt accountable for such care of the criminal insane as the statutes seemingly require. The problem was examined by the Royal Commission appointed in 1936 to investigate the penal system of Canada.(5) After considering the manner in which insane persons were dealt with under the law, this Archambault Commission made several pertinent recommendations:

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(1) The seven provinces are British Columbia, Saskatchewan, Ontario, Manitoba, Quebec, New Brunswick and Newfoundland. Medical certification is required in British Columbia, Manitoba, Quebec and Newfoundland. Saskatchewan legislation refers only to "evidence satisfactory to the Lieutenant-Governor in Council". In practice, the Cabinet accepts the recommendations of the Director of Psychiatric Services based on examination by a psychiatrist or the gaol physician.

(2) Penitentiaries Act, S.C. 1953, c. 206, sec. 58.

(3) Penitentiaries Act, S.C. 1953, c. 206, sec. 61

(4) Penitentiaries Act, S.C. 1953, c. 206, sec. 63.

(5) Royal Commission on the Penal System of Canada. Ottawa: King's Printer, 1938, pp. 149-158.

(a) The federal government has power under the Penitentiaries Act to refuse custody of an insane convict, a time period of three months after entry being allowed to determine the condition of insanity.

(b) Notwithstanding the prior responsibility of the province for the care of persons adjudged insane at the time they were received in the penitentiary, as summarized above, the cost of their maintenance during the term of their sentence ought to be provided by the Parliament of Canada.

(c) The law might well be amended to provide for the examination of alleged insane prisoners by independent alienists of wide experience.

ADMINISTRATION OF MENTAL HEALTH SERVICES

Like other health services, care of the mentally ill and the mentally defective is primarily a function of the provinces. Accordingly, the federal government assumes direct responsibility for only special groups. Through its Department of Veterans' Affairs it provides services for mentally ill war veterans. Indians and Eskimos are cared for in the provincial mental hospitals which are reimbursed at a daily rate per patient by the federal authorities. In addition to these direct responsibilities, the federal government serves in a consultative capacity, gives financial assistance through various grants and participates in research and educational activities. The Dominion Council of Health and its Advisory Committee on Mental Health facilitate co-operation and the co-ordination of effort in the provision of mental health services.

Local governments may sometimes provide mental hospital services - as in Nova Scotia where roughly one-half of the beds in the County and Municipal Homes are occupied by mental patients - but usually their contributions are limited to clinical services and educational work. In the voluntary field, the Canadian Mental Health Association has played a significant role since 1918 and other organizations are becoming increasingly active.

Mental health services are administered by separate divisions within the health departments in eight of the ten provinces. Newfoundland has a centralized administrative system for health services in general and has no separate mental health division. In British Columbia, mental health services are a responsibility of the Department of the Provincial Secretary.

Provincial Administration

Newfoundland. In Newfoundland, mental health services are centred in the provincial mental institution, the Hospital for Mental and Nervous Diseases, located at St. John's. On behalf of the Deputy Minister of Public Health, the hospital superintendent administers the program of community out-patient, consultant and educational services as well as the in-patient psychiatric care.

Prince Edward Island. A Division of Mental Health was established within the Department of Health and Welfare in 1949, under a director responsible to the Chief Health Officer. Mental hospital services are integrated with community clinic services under the same director.

Nova Scotia. Organized services for the mentally ill and defective are provided through the provincial Department of Health, the Department of Welfare and various local government agencies. A Division of Neuro-Psychiatry was established in 1947 as a part of the health department. Its director is responsible for the integration of various services and for the development of the overall program. He exercises general supervision over the provincial mental hospital, administers the field psychiatric service and serves as head of the Department of Neurology, Neuro-surgery and Psychiatry at the provincially operated Victoria General Hospital.

In addition to the single mental hospital administered by the province, patients are hospitalized in 17 of the county and municipal institutions financed and administered by local authorities. Since these homes, asylums and hospitals combine custodial and medical care, inmates may be hospitalized by local welfare agencies under the Poor Relief Act or may be committed as mental patients by physicians with approval of the provincial Inspector of Humane and Penal Institutions.

The Nova Scotia Training School for Mental Defectives is administered by the provincial Department of Welfare. However, the Department of Health provides a psychiatric consultant for the Training School and psychologists for the Department of Welfare's child welfare program and for the Department of Education's mental testing service. Mental health education is carried on by the Department of Education and by the provincial division of the Canadian Mental Health Association.

New Brunswick. In New Brunswick a separate Division of Mental Health was established in 1950 within the Department of Health and Social Services under a full-time director. The Division administers a comprehensive program including mental hospital services, community clinics, the Boys' Industrial Home for emotionally disturbed juveniles and co-operates with the provincial division of the Canadian Mental Health Association in public education and research.

Quebec. Although Quebec's provincial Department of Health maintains a Division of Psychiatric Hospitals, mental institutions and clinics are operated mainly by voluntary organizations, both lay and religious. Each of the general-purpose mental hospitals is affiliated with a university for teaching purposes. Responsibility for the development of mental health services rests

chiefly with the Universities of Laval, Montreal and McGill which co-operate with the mental hospital authorities. Furthermore, the universities serve to co-ordinate community out-patient and in-patient services provided by the affiliated general hospitals.

The provincial Division of Psychiatric Hospitals administers one institution for mentally ill prisoners, appoints medical superintendents to the various mental hospitals,(1) exercises regulatory supervision over admissions, pays maintenance costs for public patients and maintains extensive statistics.

Special facilities for epileptics and mental defectives have been developed and are administered by religious and lay groups. Various voluntary organizations participate in the development of community services. Educational and child guidance services are provided in part by local health units and by the City of Montreal Health Department.

Ontario. The provincial Department of Health administers mental hospital services and training schools for mental defectives through its Hospital Division. Travelling clinics and out-patient departments are operated by some provincial hospitals but most community and child guidance clinics are administered by municipal health departments and local health units. The Department of Education is responsible for maintaining special classes for the higher grade mental defectives, while voluntary groups are becoming progressively more active in organizing day schools for children of less ability. The Canadian Mental Health Association with national headquarters in Toronto has been especially active in organizing and directing community services. The Medical Statistics Division of the Department of Health assembles and analyses mental health data.

An increasing number of general hospitals are providing both in and out-patient psychiatric services. Recent legislation(2) provided for the appointment of a Director of Mental Health and such mental health officers as the Minister deems desirable to supervise both in and out-patient services provided by general hospitals, to

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(1) These appointments are made in collaboration with the universities concerned.

(2) Bill No. 92: An Act Respecting Mental Health, 1954, cited as "The Mental Health Act, 1954".

inspect accommodation, to inquire into admission and discharge procedures and to promote and co-ordinate community mental health services and resources.

Manitoba. In Manitoba, a Division of Psychiatric Services was established as early as 1928, under direction of a Provincial Psychiatrist responsible to the Deputy Minister of Health and Public Welfare. This Division administers all mental hospitals in the province including a training school for mental defectives, organizes and assists in operating community services. Various general hospitals and the Winnipeg School Board participate in providing child guidance services for the metropolitan area.

Saskatchewan. The Psychiatric Services Branch is one of five major administrative branches of Saskatchewan's Department of Public Health. It was established in 1950 as a part of the general reorganization of the entire department, but had existed earlier as a Division of Mental Services. The Psychiatric Services Branch is responsible for the administration of the whole provincial mental health program including mental health education and community clinics as well as the institutional services. Public health staff of the local health regions co-operate with the work of the community clinics. A provincial division of the Canadian Mental Health Association has been active in educational work since 1951.

Alberta. The general administration of mental health services in Alberta is centered in the Division of Mental Health, Department of Public Health. This Division operates mental hospitals, a training school for mental defectives, community and child guidance clinics and public health educational services.

School boards in the two major cities provide auxiliary classes for mentally retarded children and employ teacher-psychologists. Some local health units have developed experimental preventive mental health programs.

Under the Sexual Sterilization Act, a special Eugenics Board has been appointed to recommend sterilization of mentally deficient or mentally ill persons as deemed necessary.

British Columbia. British Columbia is unique in that its mental health services are administered by the Department of the Provincial Secretary rather than its health department. A director, appointed under the Mental Hospitals Act, officially supervises all

services including the public mental hospitals, the provincial clinic of psychological medicine, the training school for mental defectives, the provincial homes for the aged and the provincial child guidance clinics. In charge of each mental institution is a medical superintendent who reports to the director and who is empowered by the Act to direct and control the medical treatment of patients and the internal management of the hospital.

The Metropolitan Health Committee of Greater Vancouver and the Department of Education co-operate in providing mental health services for the city's school children.

The Federal Department of Health and Welfare

Several divisions in the federal government perform functions related to mental health. The Mental Health Division serves in a consultant rather than administrative capacity. It promotes mental health programs, compiles educational materials for the provinces, provides consultant services to provincial health departments and to other divisions of the Department of National Health and Welfare. It also serves in an advisory capacity with respect to the administration of the Mental Health Grant, encourages research and undertakes special surveys.

The Directorate of Health Insurance Studies is directly responsible for the administration of the Mental Health Grant. The Information Services Division assists the Mental Health Division in compiling and distributing educational materials. The Research Division maintains a continuous analysis of mental health legislation, assists with the planning, conduct and analysis of surveys, maintains information on mental health services and resources especially as they pertain to the Mental Health Grant, and compiles reports on request. It also serves in an advisory capacity to the Dominion Bureau of Statistics in matters relating to the collection of mental health statistics.

The Advisory Committee on Mental Health

To advise the Minister of National Health and Welfare on matters pertaining to mental health in Canada, the establishment of an Advisory Committee on Mental Health was authorized by Order-in-Council in August, 1947.(1) This order fixed membership at

(1) Order-in-Council P.C. 118/3465, dated August 27, 1947

fifteen, excluding the chairman and secretary of the committee and the Chief of the federal Mental Health Division. Members are appointed by the Minister of National Health and Welfare. In 1953, the Committee was comprised of the ten provincial mental health directors and five professional persons. Duties are clearly delineated in the order:

> The Advisory Committee on Mental Health... shall facilitate co-operation between the Mental Health Division and the provincial mental health services with a view to the exchange of information, the co-ordination of effort and activities in order to ensure the existence and maintenance of the highest standard of mental health services and procedure.

Voluntary Mental Health Associations

Since its inception in 1918, the Canadian Mental Health Association has actively promoted mental health work. At the present time (1954) its major role is consultative and educational. Provincial divisions of the Canadian Mental Health Association have recently been organized as follows:

Nova Scotia,	1951	British Columbia,	1952
New Brunswick,	1951	Ontario,	1952
Saskatchewan,	1951	Manitoba,	1953
		Alberta,	1954

The association's national office in Toronto, headed by a General Director, maintains close liaison with the federal Mental Health Division and with the provincial divisions which, in turn, co-operate closely with their respective provincial governments.

Statistics on Mental Illness

Under the British North America Act of 1867 responsibility for the assembling of statistics was allocated to the federal government. A special federal agency, the Dominion Bureau of Statistics, was established specifically for the purpose and was authorized to collect, compile and publish data on virtually all aspects of national life. In the field of health which includes the area of mental illness, source data are assembled and collated within the framework of a working arrangement between the Dominion Bureau of Statistics and the provincial health departments.

The present system of collecting statistics on mental illness originated in 1931. At that time the Bureau undertook to publish an annual report on mental institutions, based on data from two types of returns: a schedule completed and submitted yearly by each mental institution and an individual reporting card for each patient, prepared at the time of his admission, transfer, discharge or death. In recent years, supplementary schedules have been designed for mental health clinics and hospital out-patient departments, while the individual card system has been broadened to cover returns from psychiatric units in general hospitals.

The statistical returns are designed to yield information on four main aspects of mental illness:

a. The amount, nature and utilization of institutional accommodation and facilities available for treatment.

b. The incidence and nature of institutionalized mental illness and mental defect, and the characteristics of the patient.

c. The nature, duration and results of hospital treatment.

d. The operating costs, revenues and financial conditions of the mental institutions.

The annual schedules submitted by the institutions provide information regarding the type and ownership of a hospital, the standard bed capacity and the actual number of patients in hospital on a given date, the number of patient-days for the year, the average daily in-patient caseload and the number of patients treated for tuberculosis. In addition, the schedule records the types of organized services and service activities, the number of personnel employed and the educational programs provided by the institution.

Data on the incidence and nature of mental illness or mental deficiency derive from the individual reporting cards, submitted monthly. Admission cards provide vital statistics, the source of admission and diagnosis; separation cards indicate the reason for separation, the disposition of the patient, the duration of residence in the hospital, the final diagnosis and, where necessary, the cause of death. To achieve uniform classification of mortality and morbidity rates for mental illness, Canada, as a member of the World

Health Organization, has adopted the "International Statistical Classification of Diseases, Injuries and Causes of Death" (sixth revision).

The special schedule for mental health clinics and hospital out-patient departments is distributed by provincial authorities. In broad terms, the statistical returns provide an annual measure of the growing volume and utilization of clinical and out-patient services. Information gathered includes the numbers and types of personnel employed, the numbers of clinics held and the attendance by children and/or adults.

At the end of each fiscal year, the financial schedule is completed by all mental institutions whose revenues and expenditures are independent of the financial system of a general hospital or sanatorium. Each institution submits a statement of operations, reporting the major items of revenue and expenses for current operation and also the amount, source and expenditure of capital funds.

The number of institutions which have adopted the card system of reporting has increased steadily since its inception. In 1932, 31 of the 56 mental institutions then operating in Canada submitted admission and separation cards. By 1952, 75 institutions were reporting some information to the Bureau of Statistics, and schedules were received on 80 percent of all patients admitted.

INSTITUTIONAL CARE OF THE MENTALLY ILL

In this discussion of the institutional care of the mentally ill in Canada, the term "mental institution" is used to designate hospitals which operate primarily for the care and custody of the mentally ill and/or mentally defective, under direction of the provincial mental health services. Whether public or private, all such institutions are established and administered by statute. In nine of the provinces they are controlled by the departments of health; in British Columbia, they are under the Department of the Provincial Secretary.

In most provinces, the majority of mental institutions are provincially owned and operated, as indicated in Table III. Only in two provinces are public hospitals otherwise administered - the county homes in Nova Scotia and the Quebec hospitals which are under religious or lay auspices.(1) Two federal hospitals have special facilities for the care and treatment of veterans with mental disturbances attributable to war service. Private mental hospitals are rare in Canada; the few in operation are located in Ontario and British Columbia.

At the end of 1953, there were 84 known institutions in Canada(2) which provided care for over 60,000 patients with various types of mental disorders. Of these, hospitals providing accommodation and treatment for all types of mental illness comprise by far the largest group, numbering 35 out of the 84. Such hospitals may also receive epileptics, seniles and alcoholics.

A few provinces have established separate hospitals or units for certain special classes of mentally ill patients as illustrated in Table IV. Homes for the senile aged are an integral part of the mental hospital system in British Columbia; Ontario and Quebec have separate hospitals for epileptics; four provinces, British Columbia, Ontario, Quebec and Newfoundland have provincial hospitals or units to care for mentally ill prisoners, while Ontario has a private hospital for alcoholics. Separate units or wards for the care of tuberculous mental patients have been established in all provinces; Ontario maintains a separate hospital for this purpose.

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(1) Hospitals in Quebec operate within the framework of the provincial mental health services.

(2) See Table IV.

TABLE III. MENTAL INSTITUTIONS REPORTED IN CANADA: BY TYPE OF OWNERSHIP, December 31, 1953.

Province	Public Mental Hospitals					Private Hospitals	Totals
	Provincial	Lay	Religious	County or Municipal	Federal		
Newfoundland	1						1
Prince Edward Island	2						2
Nova Scotia	2			17			19
New Brunswick	2						2
Quebec	1	4	11		1		17
Ontario	17				1	3	21
Manitoba	4						4
Saskatchewan	4						4
Alberta	6						6
British Columbia	7					1	8
Canada	46	4	11	17	2	4	84

Source: D.B.S. Mental Institutions, 1953, and Provincial Health Survey Reports.

TABLE IV. MENTAL INSTITUTIONS REPORTED IN CANADA; BY CLASS OF PATIENT
December 31, 1953.

Province	A. Hospitals - Schools for Mental Defectives	B. Institutions for the Mentally Ill							Veterans	Totals
		Hospitals for all classes of mentally ill	Psychiatric Hospitals	Infirmaries and Municip. Homes	Homes for senile aged	Epileptics	Alcoholics	Criminal Insane		
Nfld		1								1
P.E.I.		1		1						2
N.S.	1	1		17						19
N.B.		2								2
Que.	2	7	3			3		1	1	17
Ont.	3	13	1			1(a)	1	1(b)	1	21
Man.	1	2	1							4
Sask.	1	2	1							4
Alta.	1	4			1					6
B.C.	1	2	1		3			1		8
Canada	10	35	7	18	4	4	1	3	2	84

(a) This hospital consists of two divisions - one for tuberculous mental patients and one for epileptics.
(b) Accommodation for the criminal insane constitutes only a part of the total hospital accommodation.

Source: D.B.S. Mental Institutions, 1953, and Provinical Health Survey Reports.

Residential schools for mental defectives have been established in all provinces except Newfoundland, Prince Edward Island and New Brunswick. At the end of 1953, 10 training schools were in operation in Canada.

In Nova Scotia and Prince Edward Island, county homes or infirmaries provide accommodation for the mentally ill who have been diagnosed as "harmless insane or feeble-minded". In 1953, seventeen county homes or hospitals in Nova Scotia maintained accommodation for such patients, and one infirmary was operated by Prince Edward Island.

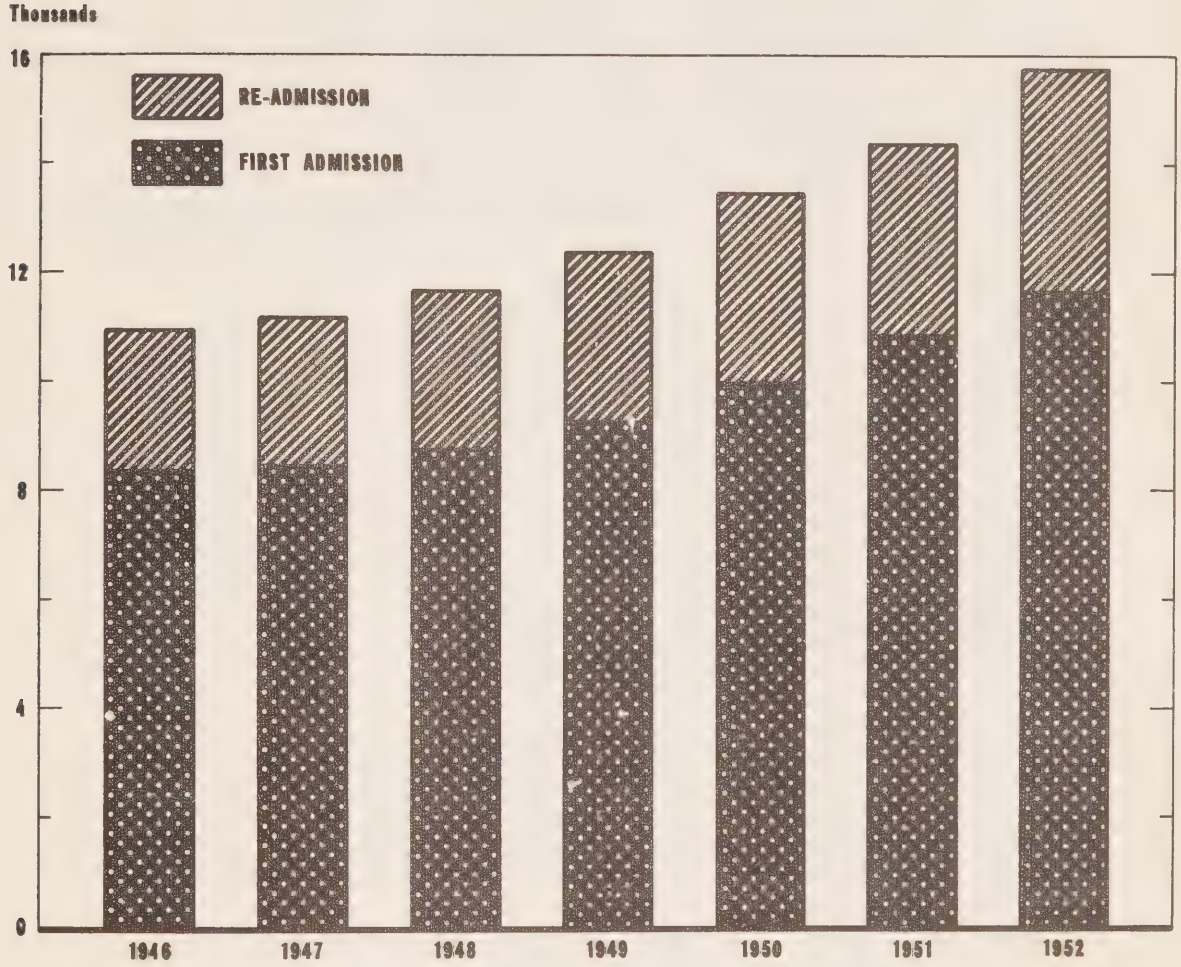
A special type of institution providing modern facilities and techniques for short-term therapy is the psychiatric hospital, designed primarily for patients who may benefit from temporary observation and treatment. Canada has seven such hospitals or units within hospitals; the Clinique Roy-Rousseau, the Sanatorium Prevost and the Allen Memorial Institute, all in the province of Quebec; the Toronto Psychiatric Hospital in Ontario, the Winnipeg Psychopathic Hospital in Manitoba, the Munroe Wing of the Regina General Hospital in Saskatchewan and the Crease Clinic of Psychological Medicine at Essondale, British Columbia. In these psychiatric hospitals the term of treatment may be limited by statute to a specified period; in most instances, if further therapy is deemed desirable, the superintendent is empowered to arrange transfer of the patient to a mental hospital.

In recent years there has been a growing recognition of the role of the general hospital in providing psychiatric services. In addition to providing out-patient treatment and diagnostic services a number of general hospitals maintain a separate psychiatric treatment unit; other hospitals have a more restricted active treatment program with no specific bed allocation and some have a limited treatment service but no organized clinical service in psychiatry.

MENTAL INSTITUTION ACCOMMODATION

For well over a century the history of Canada's mental hospitals has been a record of bed shortages both with respect to the needs of the general population and to overcrowding within the institutions. At the time of the provincial health surveys in 1948, waiting lists for admissions and overcrowding in the hospitals were reported by all the provinces. While bed shortages were noted by all, they were more acute in some areas than in others.

TOTAL ADMISSIONS TO MENTAL INSTITUTIONS



SOURCE: Table 18

Research Division, N. H. & W.

Table V records the rated bed capacities as compared with the number of beds set up in 1948, by province. As indicated, the rated bed capacity for all of Canada totalled 41,322, while 53,326 beds were actually in use at the end of that year. Accordingly, 129 beds were set up for every 100 beds for which the hospitals provided adequate space and facilities. The least overcrowding existed in Nova Scotia(1) and Alberta; the greatest, in Newfoundland where accommodation existed for 263 beds but where 650 were occupied on December 31st. These data, supplied by the provincial health survey committees, are probably the most accurate on record for that year.

By 1953, there was still considerable overcrowding in mental institutions although extensive provincial construction programs had reduced the number of beds set up as a percentage of standard bed capacity to 119.(2) From December 31, 1948, to December 31, 1953, daily in-patient population rose from 53,326 to 61,010, an increase of 14 percent over the five years.(3) During the same period standard bed capacity, as reported by mental institutions, rose from 41,322 beds to 51,370 beds, an increase of 24 percent. Although it appears that the 1953 rated bed capacity may have been overstated in a few instances, some progress had been made in reducing overcrowding in mental institutions as a whole.

In only two provinces, New Brunswick and Ontario had the average daily in-patient population increased more than standard bed capacity, and this situation had been partially remedied in both provinces by the occupation of newly constructed accommodation in June, 1954.

Although a substantial number of new beds have been built and overcrowding reduced, the demand for accommodation in mental institutions has remained high (4)

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(1) The statistics for Nova Scotia include some senile patients in county and municipal institutions who were not mentally ill. Overcrowding in the provincial mental hospital and training school was more serious than the above statistics indicate.

(2) The federal standards for estimating bed capacity were revised between 1948 and 1953. The change, however, does not appear sufficient to invalidate these comparisons.

(3) See Table V.

(4) See Chart I. From 1946 to 1952 total admissions to mental institutions rose from 11,000 to nearly 16,000 a year.

TABLE V. BED CAPACITY AND AVERAGE DAILY POPULATION IN MENTAL INSTITUTIONS:
December 31, 1948 and 1953

Province	1948[1]			1953[2]		
	Rated Bed Capacity	Average[3] Daily Population	Daily Population as a percentage of bed capacity	Standard Bed Capacity	Average Daily Population	Daily Population as a percentage of bed capacity
	Number	Number	%	Number	Number	%
Newfoundland	263	650	247	526	824	157
Prince Edward Island	200	305	153	300	300	100
Nova Scotia [4]	2,439	2,781	114	3,042	3,071	101
New Brunswick [5]	912	1,395	152	910	1,607	177
Quebec	11,776	15,566	132	15,916[6]	16,858	106
Ontario	13,093	16,041	123	14,513	18,897	130
Manitoba	2,392	3,165	132	2,912	3,420	117
Saskatchewan	2,877	4,463	155	3,100	4,630	149
Alberta	2,658	3,128	118	3,809	3,951	104
British Columbia	3,587	4,690	131	4,871	6,170	127
Federal Hospitals	1,125	1,142	102	1,471	1,282	87
Canada	41,322	53,326	129	51,370	61,010	119

(1) Provincial Health Survey Reports.
(2) D.B.S. Mental Institutions, 1953.
(3) Estimated on basis of average beds set up.
(4) Includes some beds in county and municipal institutions occupied by senile patients.
(5) A 225 bed mental unit was opened in June 1954.
(6) Over-estimates standard bed capacity.

The existence, in 1954, of waiting lists for nearly all mental institutions is evidence that more facilities are needed if all who require treatment are to obtain it.

The extent of this shortage, however, is difficult to estimate. There is little exact information about the extent of psychiatric morbidity in the population and variations in the incidence of mental disease in different types of communities and occupations makes it difficult, at present, to formulate reasonable estimates of the number of unhospitalized mentally ill in Canada.(1) Moreover, an estimate of mental illness in the general population would not yield a reliable estimate of the number of mental hospital beds needed in Canada. The growth of psychiatric out-patient clinics, day treatment centres and day centres for mental defectives, all may reduce the need for residential hospital accommodation. Similarly, changes in medical treatment may alter the duration of stay in a mental hospital in such a manner that the period of hospitalization for each patient would be substantially reduced. This would increase the turnover of hospital patients, effectively increasing hospital capacity. Other variables, which make even crude forecasting of future needs difficult, are the rate of obsolescence of mental hospitals, the rates of population growth and migration, and changes in the age distribution of the population.

The provinces, however, are striving to reduce waiting lists through the completion of hospital accommodation now under construction and through construction planned for the next four years. Between 1948 and 1954, provincial governments, with the assistance of the federal government,(2) completed accommodation for 6,328 beds and were constructing accommodation for 5,169 beds as indicated in Table VI. Of the 11,551 beds completed or in the course of construction, 4,571 beds were in mental hospitals, 6,507 beds were in institutions for the mentally defective and 473 in general and psychiatric hospitals. The distribution, by type of institution and province, is shown in Table VII.

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(1) World Health Organization, Technical Report Series No. 73, Third Report of the Expert Committee on Mental Health, Geneva, September, 1953, pp. 3-4. R.H. Felix, M.D., Mortin Kramer, D.Sc., Research in Epidemiology of Mental Illness, U.S. Public Health Reports, Vol. 67, No. 2, February, 1952, pp.152-160.

(2) These statistics relate only to construction jointly financed by federal and provincial governments. No information is available about construction not financed in this manner.

TABLE VI. INSTITUTIONAL ACCOMMODATION COMPLETED OR UNDER CONSTRUCTION: April 1948-June 1954 (1)

Province	Completed Accommodation, 1948-54	Accommodation Under Construction, 1954
	No. of Beds	No. of Beds
Newfoundland	308	--
Prince Edward Island	---	40
Nova Scotia	276	340
New Brunswick	236	500
Quebec	2,380	413
Ontario	1,391	2,251
Manitoba	632	--
Saskatchewan	---	1,181
Alberta	408	214
British Columbia	751	230
Canada	6,382	5,169

(1) Includes only accommodation built by provincial governments which was financed, in part, by the Federal Hospital Construction Grant.

TABLE VII. ACCOMMODATION COMPLETED OR UNDER CONSTRUCTION: BY TYPE OF MENTAL INSTITUTION,
April 1948 - June 1954 (1)

Province	Mental Hospitals	Institutions for Mental Defectives	General and Other Hospitals	Total Construction
	Number of Beds	Number of Beds	Number of Beds	Number of Beds
Newfoundland	308			308
Prince Edward Island	40			40
Nova Scotia	552	64		616
New Brunswick	725		11	736
Quebec	1005	1639	149	2793
Ontario	627	2805	210	3642
Manitoba	350	282		632
Saskatchewan		1116	65	1181
Alberta	283	301	38	622
British Columbia	681	300		981
Canada	4571	6507	473	11551

(1) Includes only accommodation built by provincial governments which was financed, in part, by the Federal Hospital Construction Grant.

The following discussion of hospital accommodation in the provinces is based partly on data collected during the provincial health surveys and partly on subsequent reports, accounts and correspondence. Since reporting systems sometimes differ, data are not comparable from province to province.

Newfoundland Newfoundland's single mental institution, the Hospital for Nervous and Mental Diseases, provides active treatment beds primarily for psychotic patients over ten years of age. Since 1948, 274 new beds have been added to this institution. Senile patients are not admitted to this hospital except in extreme cases where they are unmanageable in the home or dangerous to those around them. Relatively healthy male senile cases are generally cared for in a 126 bed chronic maintenance psychiatric unit at the St. John's General Hospital. There are no special schools or hospitals for mental defectives in the province.

Prince Edward Island. Prince Edward Island has only one admission and active treatment centre, the Falconwood Hospital. In 1954, a 50 bed admission and treatment unit was under construction which was expected to help relieve overcrowding in the institution by 1955. Accommodation in the Falconwood Hospital is supplemented by the Provincial Infirmary which cares for mental defectives of all ages and for seniles. On December 31, 1951, there were 100 mental defectives and 16 senile patients in the infirmary. Additional accommodation for seniles is provided in the Beach Grove institution, operated by the Welfare Division, Department of Health and Welfare.(1)

Nova Scotia. Institutions for the care of mental patients in Nova Scotia include the Nova Scotia Hospital, the Nova Scotia Training School for Mental Defectives and a system of county homes and hospitals. While the bulk of custodial care is given by the county homes, these institutions have limited facilities so that on admission the majority of mental patients pass through the Nova Scotia Hospital for diagnosis and desirable treatment.

In 1948, the estimated rated bed capacity of all institutions was 2,439 but 2,781 beds were actually set up,(2) resulting in general overcrowding to the extent

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(1) The figures for the provincial infirmary and for Beach Grove have not been included in Table V.

(2) Includes some beds occupied by seniles not mentally ill.

of 16 percent. By 1954, 276 beds had been added - 64 to the Nova Scotia School for Mental Defectives and 212 to the Halifax County Home and Mental Hospital at Cole Harbour and overcrowding was considerably reduced. In addition, 228 beds were being constructed at the Nova Scotia Hospital and 340 beds at the Cape Breton County Hospital. The Victoria General Hospital provides in-patient psychiatric treatment for patients transferred from other departments of the hospital. During 1951-52, 37 patients were cared for by this in-patient service.

New Brunswick. Until 1954, New Brunswick had only one mental institution, the Provincial Hospital at Lancaster. In 1948, this had a rated bed capacity of 912 but 1,395 beds were set up - 52 percent more than normal capacity. In reporting on the hospital situation, the Provincial Health Survey Committee estimated that by 1961 a total of 3,110 beds would be essential and that 2,580 beds were needed in 1948 - 2,064 beds for the mentally ill and 516 beds for mental defectives.

To alleviate overcrowding and to provide accommodation for persons on waiting lists, a new mental hospital of 725 bed capacity is being built at Campbellton, the first 225 bed wing of this hospital was opened in June, 1954. Eleven beds for psychiatric patients have been added to the Moncton General Hospital.

Quebec. As indicated earlier, the province of Quebec has a variety of mental institutions operated chiefly by lay organizations and religious orders. A summary of rated bed capacities and beds actually set up on December 31, 1948 is provided in Table VIII which shows beds set up exceeding bed capacity by 32 percent. Obviously, overcrowding varied from hospital to hospital as it does among provinces, but the greatest degree of overcrowding seemed to be in the Montreal area. In addition to overcrowding within the hospitals, a waiting list of 1,863 names was reported by the Provincial health survey committee.

By June, 1954, accommodation for an additional 2,380 beds had been provided in Quebec. Of these, 1,639 were in institutions for mentally defective children and adults, 592 in mental hospitals and 149 in general and

TABLE VIII. RATED BED CAPACITY AND BEDS SET UP: QUEBEC MENTAL INSTITUTIONS, December 31, 1948 and 1953.

Institution	1948[1]			1953[2]		
	Rated Bed Capacity	Beds Set Up	Beds Set Up as a Percentage of Bed Capacity	Standard Bed Capacity	Average Daily In-patient population	Daily Population as a Percentage of Bed Capacity
	Number	Number	%	Number	Number	%
Hôpital Saint-Michel-Archange	4,000	4,305	108	4,000	4,416	110
Hôtel-Dieu du Sacre-Coeur de Jesus	185	185	100	275	265	96
Hôpital Sainte-Anne	820	1,109	135	515	1,139	221
Hôpital Saint-Julien	750	959	128	955	931	97
Verdun Protestant Hospital	1,247	1,604	128	1,180	1,645	139
Hôpital Saint-Jean-de-Dieu	3,684	6,075	165	5,830[3]	5,825	100
Retraite Saint-Benoit	200	206	103	105	100	95
Sanatorium Prévost	52	52	100	87	64	74
Les Etablissements Notre-Dame	80	105	131	80[4]	105[4]	131
Dieppe House	103	75	73	84	78	93
La Société de Réhabilitation de Sherbrooke	80	88	110	180[4]	180[4]	100
Institut Médico-Pédagogique Mont-Providence	-	-	-	1,000	484	48
Hôpital Sainte-Elizabeth	-	-	-	785	661	84
Hôpital de Bordeaux	532	760	140	755	906	120
Allen Memorial Institute	43	43	100	85	59	69
Totals	11,776	15,566	132	15,916	16,858	106

(1) Statistics Derived from Report of Quebec Health Survey Committee.
(2) D.B.S. Mental Institutions, 1953.
(3) Over-estimates standard bed capacity.
(4) Estimated Research Division.

other hospitals.(1) An additional 413 mental hospital beds were in process of construction in 1954.

Ontario. In 1948, the Department of Health operated 14 mental institutions and the Toronto Psychiatric Hospital. The number of patients under care compared with the rated bed capacity of each of these institutions is shown in Table IX. As pointed out earlier, the estimated bed capacity at the end of 1948 was 13,318; beds set up exceeded bed capacity by 22 percent with roughly the same degree of overcrowding for mentally ill, mental defectives and epileptics in provincial hospitals.(2) Waiting lists were especially long for mentally defective children.(3)

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(1)

Institution	Type of Accommodation	No. of Beds
Institute Medico-Pedagogique Mont-Providence	Mentally Defective	1269
La Societe de Rehabilitation	Mentally Defective	174
Hopital Saint-Michel-Archange	Mentally Defective	196
Hopital Sainte-Elizabeth	Mentally Ill and Defective	592
Allen Memorial Institute	Psychiatric Hospital	50
Hotel Dieu Saint-Vallier	General Hospital	54
Montreal General Hospital	General Hospital	45

(2) Beds set up as a percentage of rated capacity in provincial hospitals was 123 for mental hospitals, 121 for mental defectives and 117 for epileptics.

(3) The health survey committee reported a waiting list of 1,500 children.

TABLE IX. RATED BED CAPACITY AND BEDS SET UP: ONTARIO MENTAL INSTITUTIONS, December 31, 1948 and 1953.

Institution	1948[1]			1953[2]		
	Rated Bed Capacity	Beds Set Up	Beds Set Up as a Percentage of Bed Capacity	Standard Bed Capacity	Average Daily In-patient population	Daily Population as a Percentage of Bed Capacity
	Number	Number	%	Number	Number	%
Mental Hospitals						
Brockville	750	1,069	142	750	1,187	158
Cobourg	320	514	161	320	541	169
Port Arthur	125	121	97	125	137	110
Hamilton	1,065	1,624	152	1,065	1,711	161
Kingston	945	1,102	117	945	1,098	116
London	1,100	1,475	134	1,100	1,569	143
New Toronto	1,100	1,375	125	1,100	1,548	141
Penetanguishene	450	609	135	450	591	131
Toronto	750	1,167	156	750	1,262	168
Whitby	1,500	1,683	112	1,500	1,733	116
St. Thomas	1,822	1,405	77	1,822	2,031	111
Langstaff	344	477	139	344	496	138
Hospital Schools for Mental Defectives						
Aurora	—	—	—	250	247	99
Orillia	1,800	2,170	121	1,800	2,293	127
Smith Falls	—	—	—	900	863	96
Hospital for Epileptics & Tuberculars						
Woodstock	950	1,178	124	950	1,228	129
Toronto Psychiatric Hospital	72	72	100	64	76	119
Private Hospitals						
Homewood Sanitarium	225[3]	225[3]	100	225	230	102
Bethesda Home	—	—	—	53	56	106
Totals	13,318	16,266	122	14,513	18,897	130

(1) Report of the Ontario Health Survey Committee.

(2) D.B.S. Mental Institutions, 1953.

(3) Estimated.

Between 1948 and 1954, 1,391 new beds were provided for Ontario mental patients and in 1954 accommodation for another 2,251 beds was being built.(1) Of this 3,642 bed total, 2,805 beds were in institutions for the mentally defective, 627 in mental hospitals and 210 in psychiatric units in general hospitals.

Up to 1954, the completion of new accommodation had not kept pace with the increase in population in Ontario mental institutions and daily population as a percentage of standard bed capacity increased from 122 percent in 1948 to 130 percent in 1954. However, the extensive building program, underway in 1954, should result in a rapid decline in overcrowding in the near future.

Manitoba. Manitoba has two hospitals for the mentally ill, one for mental defectives and one psychiatric hospital. In 1948 the rated bed capacity, according to federal standards, was 2,430 beds; beds set up totalled 3,203 and beds set up as a percentage of bed capacity was 132 percent. Apart from overcrowding in these institutions a waiting list of 210 mental defectives was reported These figures, distributed by hospital, are shown in the first part of Table X

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(1)

Name of Hospital	No. of beds Completed, 1954	No. of beds under construction, 1954
Ontario Hospital School, Smiths Falls	900	1,500
Ontario Hospital, Aurora	185	
Ontario Hospital, Port Arthur	306	
Ontario Hospital, Brockville		180
Ontario Hospital School, Orillia		220
Ontario Hospital, Toronto		141
Toronto Western Hospital		38
St. Michaels Hospital, Toronto		30
Sudbury General Hospital		35
Ottawa General Hospital		30
St. Catharines General Hospital		22
Plummer Memorial Hospital: Sault Ste. Marie		2
Women's College Hospital, Toronto		20
St. Joseph's Hospital, London		33
Totals	1,391	2,251

TABLE X. RATED BED CAPACITY AND BEDS SET UP: MANITOBA, SASKATCHEWAN AND ALBERTA MENTAL INSTITUTIONS, December 31, 1948 and 1953

Institution	1948[1]			1953[2]		
	Rated Bed Capacity	Beds Set Up	Beds Set Up as a Percentage of Bed Capacity	Standard Bed Capacity	Average Daily In-patient Population	Daily Population as a Percentage of Bed Capacity
	Number	Number	%	Number	Number	%
MANITOBA						
Brandon Hospital for Mental Diseases	1,300	1,629	125	1,654	1,668	101
Selkirk Hospital for Mental Diseases	700	994	142	700	1,063	152
Manitoba School for Mental Defectives	392	542	138	520	654	125
Winnipeg Psychopathic Hospital	38	38	100	38	35	92
Totals	2,430	3,203	132	2,912	3,420	117
SASKATCHEWAN						
Saskatchewan Hospital, North Battleford	1,050	1,859	177	1,076	1,854	172
Saskatchewan Hospital, Weyburn	1,100	1,926	175	1,250	1,917	152
Saskatchewan Training School	700	656	94	735	825	112
Regina General Hospital	27	22	81	39	34	88
Totals	2,877	4,463	155	3,100	4,630	149
ALBERTA						
Provincial Mental Hospital, Ponoka	1,047	1,350	129	1,205	1,596	132
Provincial Mental Institute, Edmonton	1,095	1,271	116	1,500	1,400	93
Claresholm Auxiliary Mental Hospital	100	100	100	100	100	100
Raymond Auxiliary Mental Hospital	116	116	100	135	135	100
Provincial Training School, Red Deer	300	300	100	525	465	89
Rosehaven Home for the Aged	--	--	--	344	255	74
Totals	2,658	3,137	118	3,809	3,951	104

(1) Reports Provincial Health Survey Committees.
(2) D.B.S. Mental Institutions, 1953.

Between 1948 and 1954 accommodation in the three mental hospitals was increased by 632 beds. Of these, 282 were added to the Manitoba School for Mental Defectives, 104 to the Brandon Hospital and 246 to the Selkirk Hospital. Daily population in mental institutions as a percentage of standard capacity fell to 117 percent during the period but the list of mental defectives awaiting admission to the training school increased to 300.

Saskatchewan. In 1948 Saskatchewan's two mental hospitals, the training school for mental defectives and the psychiatric wing of the Regina General Hospital had a rated bed capacity of 2,877 beds (excluding 500 beds in basement wards in the Saskatchewan Hospital at Weyburn). However, 4,463 beds were actually occupied on December 31st of that year.(1) As the figures in the second section of Table X indicate, overcrowding was so great in the two larger institutions for the mentally ill that roughly 175 beds were set up in quarters designed to shelter 100 patients

Superficially it might appear that the situation was better for mental defectives. However, the Weyburn training school had been established in temporary quarters vacated by the armed services after World War II, as an emergency measure to alleviate the overcrowding of the two hospitals until such time as permanent quarters could be built.

By 1953, the standard bed capacity of the Saskatchewan Hospital, Weyburn, had been increased by 150 beds and in-patient population as a percentage of standard bed capacity had fallen to 152 percent. Construction was also begun on new training school buildings at Moose Jaw in 1950. When completed in 1955, the School will care for 1,116 patients. Patients in the temporary training school at Weyburn and mental defectives in the mental hospitals will be transferred to this institution and overcrowding in mental hospitals will consequently be alleviated. In Saskatoon, a 45-bed psychiatric unit is being added to the University Hospital.

Alberta. In 1948, Alberta's mental institutions were among the least overcrowded in the country. However, while the number of beds in use exceeded rated capacity by only 18 percent, there were still a number of patients awaiting admission to institutions. The distribution of beds, by institution, is indicated in the Third section of Table X.

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(1) Saskatchewan Health Survey Report, Vol. II, p 30

Through new construction in 1948-53 Alberta was able to reduce overcrowding in mental institutions despite an increase in average daily in-patient population. New beds were added in all mental institutions and a special tuberculosis wing (174 beds) was constructed at the Provincial Mental Institute, Edmonton. Psychiatric units have now been opened in general hospitals in Edmonton and Calgary. The University of Alberta Hospital, Edmonton, has an 18 bed unit and the Calgary General Hospital a 20 bed unit.

British Columbia. In 1948, British Columbia mental institutions provided accommodation for 4,690 patients. With a rated bed capacity of 3,587 beds, beds set up exceeded bed capacity by 31 percent, slightly higher than the average for Canada. These figures are shown in Table XI.

By 1953, mental patients in institutions had increased by 1,480 to 6,170. With a standard bed capacity of 4,871 average daily in-patient population as a percentage of bed capacity was 127 percent, a decline of 4 percent from 1948.

Increased bed capacity was provided at both Essondale and New Westminster. At the former, a new dormitory was erected on the Colony Farm, the Crease Clinic for Psychological Medicine was completed and a 225 bed wing for the care of tuberculous mental patients will be opened in 1955; at New Westminster, accommodation and training facilities for mental defectives have been expanded.

MENTAL HOSPITALS

While diagnostic and therapeutic services for the mentally ill are provided at various institutions in Canada, care and treatment for prolonged illness are usually limited to the mental hospital or training school for mental defectives. Although there is no clear-cut distinction between psychiatric hospitals and mental hospitals either by duration of treatment or legal basis of admission, in practice the psychiatric hospital usually limits treatment to a shorter period and admits cases by less formal procedures.(1) Psychiatric

(1) There are variations in the admission procedures to psychiatric hospitals for each province. Some psychiatric hospitals are covered by special legislation which may prescribe the methods of admission and classes of patients eligible for admission. In other psychiatric hospitals there are no legal formalities governing admission and treatment; patients are admitted in much the same manner as to public general hospitals.

TABLE XI. RATED BED CAPACITY AND BEDS SET UP: BRITISH COLUMBIA, MENTAL INSTITUTIONS, December 31, 1948 and 1953

Institution	1948[1]			1953[2]		
	Rated Bed Capacity	Beds Set Up	Beds Set Up as a Percentage of Bed Capacity	Standard Bed Capacity	Average Daily In-patient population	Daily Population as a Percentage of Bed Capacity
	Number	Number	%	Number	Number	%
Provincial Mental Hospital, Essondale	2,287	3,228	141	?,611	3,475	133
Provincial Mental Hospital, Colquitz	290	290	100	222	284	128
Crease Clinic of Psychological Medicine	--	--	--	228	238	104
Hollywood Sanitarium	37	37	100	70	69	100
The Woodlands School, New Westminster	446	608	136	709	1,121	158
Home for the Aged, Port Coquitlam	368	368	100	492	465	95
Home for the Aged, Terrace	--	-	--	300	292	97
Home for the Aged, Vernon	159	159	100	239	226	95
Totals	3,587	4,690	131	4,871	6,170	127

(1) Report of the British Columbia Health Survey Committee.
(2) D.B.S., Mental Institutions, 1953.

units in general hospitals usually waive formalities regarding admission and the patient turnover is more rapid than in either psychiatric or mental hospitals. This does not imply that admission to a mental hospital is synonymous with long residence, for patients may recover and be released within a short time; however, residence in a mental hospital is extended for as long as the patient continues to benefit from treatment or requires custodial care.

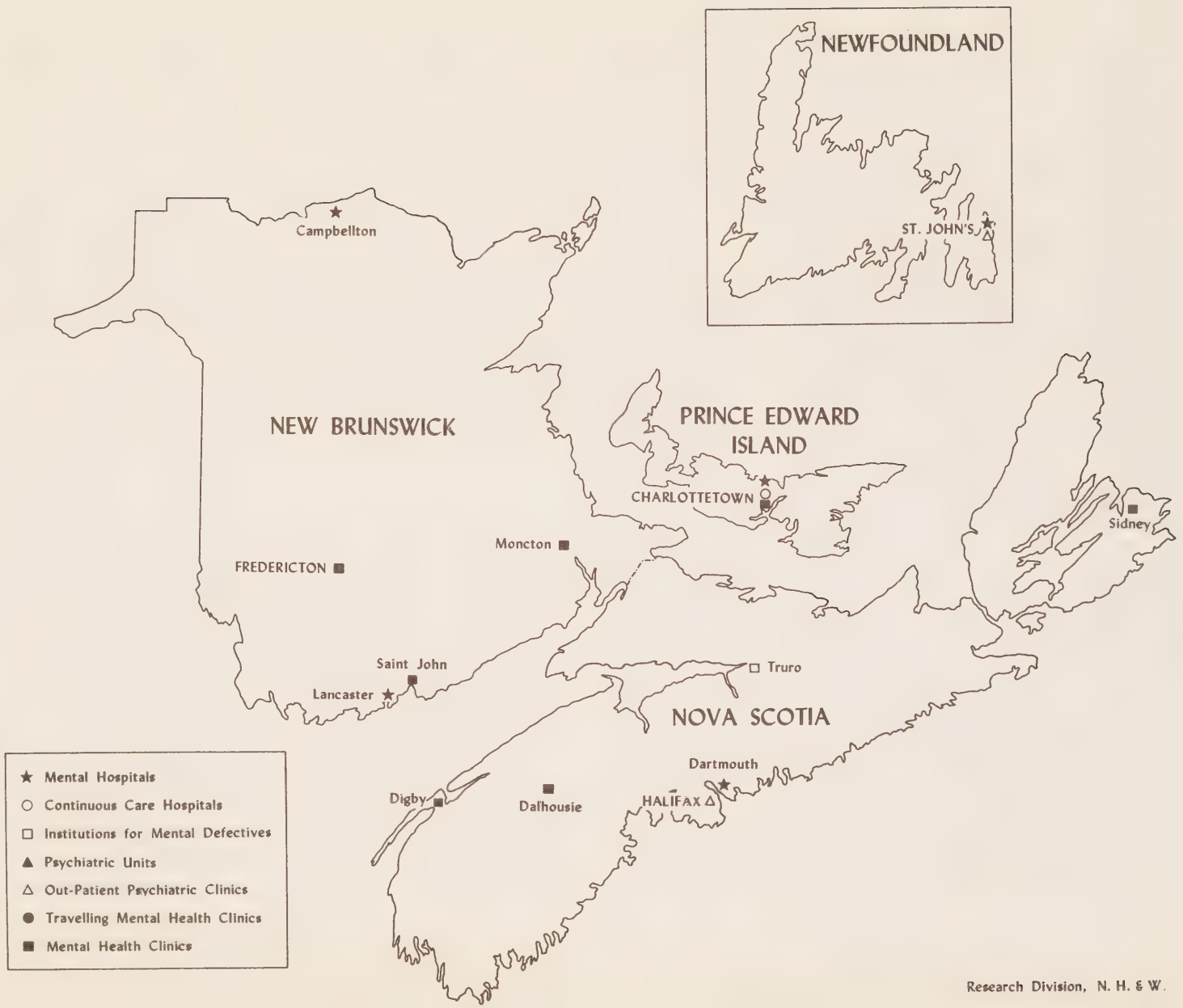
The following discussion of hospital facilities is subdivided into three parts: (1) Mental Hospitals, (2) Psychiatric hospitals, and (3) Psychiatric units in general hospitals.

Mental Hospital Facilities

No standard plan, with respect to either size or design, has governed the original construction or the expansion of Canada's mental hospitals. In most provinces mental hospitals have been located in suburban or rural areas removed from city congestion. Many of the institutions have large farms but the size of both hospital grounds and property vary. The property of the Saskatchewan Hospital at North Battleford covers well over 4,000 acres of farm land, while some institutions own only the minimum required for the site of the buildings themselves.

Most mental institutions in Canada have been built over a number of years. As the demand for additional accommodation increased, new wings were added and/or new independent units were built, usually clustered around the original building. On an average, mental institutions shelter somewhat over 1,000 patients. As indicated under "Institutional Care of the Mentally [illegible]", however, the situation varies from hospital to hospital: the largest institution in Canada, Hopital Saint-Jean-de-Dieu, in Quebec, had an average daily in-patient population of approximately 5,825 in 1954.

With regard to treatment facilities, considerable progress has been made towards equipping mental hospitals to carry on modern therapy. To-day (1954) all of the large provincial institutions have the medical and surgical units needed to provide specialized services, examinations and therapies of various kinds. Many of the large mental hospitals also have their own clinical laboratories for diagnostic work. The major problem appears to be the shortage of skilled personnel rather than lack of equipment. Additional personnel - psychiatrists, psychiatric and other nurses, psychologists and



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psychometrists, psychiatric and other social workers, laboratory technicians and occupational and recreational therapists are being trained with the aid of various provincial and federal grants and bursaries. However, the personnel problem is by no means solved.(1)

The discussion of hospital facilities, by province follows no uniform plan. In provinces which have only one or few active treatment mental hospitals the program is fairly clear-cut; in other provinces such as Quebec or Ontario where many hospitals exist and where most of the hospitals provide an active treatment service, it seemed best to group the various institutions Accordingly, the discussion of Quebec institutions (and later clinics) centres around the universities, while Ontario mental institutions are grouped according to health regions.(2)

Newfoundland. The Hospital for Mental and Nervous Diseases in St. John's is the centre for administering the provincial mental health services. As mentioned earlier, its medical superintendent is directly responsible to the provincial health department; all institutional personnel are government employees

Facilities are available in the hospital for modern therapy. Insulin, electroshock and combined insulin and electro therapy, x-ray and electroencephalographic services, dispensary and laboratory facilities are provided for diagnosis and treatment of both in and out-patients. Surgical services including lobotomy are given as needed Two 10 bed insulin wards were in operation during 1951 and a total of 188 patients received treatment;(3) electroshock was administered to 132 cases(4) and prefrontal lobotomies performed on 26 patients.(5) Necessary general surgery is also carried out.

In 1954, the medical staff of this Hospital consisted of the Medical Superintendent, Clinical Director, Assistant Clinical Director, four psychiatrists, and a resident physician.(6) There is also a full-time

(1) For details on training, see "Mental Health Personnel"

(2) Refer to maps opposite pages 58,62,66,70,72,74 and 76.

(3) 138 out-patients; 50 in-patients.

(4) 132 out-patients; 76 in-patients.

(5) Twelve of the 26 lobotomy cases were later discharged from the hospital to return to their homes

(6) One psychiatrist is receiving special training at Dalhousie University (May, 1954).

resident dentist at the hospital. One psychologist was employed in 1951; another is being added in 1954.

Occupational and recreational therapy services have been expanded in recent years. However, a shortage of trained occupational therapists has necessarily limited the scope of this service. The Social Service Department assumes a major part of the responsibility for the family care program, participates in the training program and is active in rehabilitation work with both in and out-patients. Three social workers and a supervisor were employed in 1954.

Prince Edward Island. In Prince Edward Island, the Falconwood Hospital is under the direction of the provincial Director of Mental Health Services who also serves as superintendent of the Infirmary. Originally the Infirmary - an annex of the hospital - was established to care for the poor and infirm. Due to overcrowding in the main institution, however, selected patients (usually mental defectives) have been transferred to the Infirmary.

Only the Falconwood Hospital is equipped for active treatment. Electro-shock therapy was introduced in 1951, but no facilities are available for insulin shock.(1) In 1953 a part-time neuro-surgeon was engaged and a prefrontal lobotomy service initiated.(2) Bimonthly visits are made by consultants in psychiatry from the Department of Psychiatry, Dalhousie University and a consultant service in neurology is provided by a specialist from Halifax. A Department of Psychology has been in operation since September, 1951, and is gradually expanding its psychometric services. It is expected that an electroencephalographic service will be introduced during 1954. Patients requiring other medical or surgical services are treated at the Prince Edward Island Hospital or the Charlottetown Hospital. Laboratory services are provided by the provincial laboratory.

A full-time occupational therapist and two assistants were appointed in 1951, and a recreational supervisor in 1953 to look after the non-medical therapy. A psychiatric social worker was also engaged in 1951.

The Provincial Infirmary is limited primarily to custodial care. Where necessary, treatment facilities are provided in the Falconwood Hospital and patients are transferred to the major institution for the duration of therapy.

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(1) Annual Report, Department of Health and Welfare, 1951-52, p. 118.

(2) Nine prefrontal lobotomies were performed in 1953.

Nova Scotia. The only centre for in-hospital treatment of the mentally ill in Nova Scotia is the Nova Scotia Hospital at Dartmouth. The network of county hospitals, asylums and homes are primarily for the care of mentally ill patients who are unable to benefit from an active treatment program.

Under statutory provisions the county and municipal institutions may shelter indigent persons as well as the harmless mentally ill.(1) In 1953, out of 17 local institutions, 4 were restricted to mentally ill, 2 provided care predominantly for mental patients and 11 had mixed populations.(2) On March 31, 1953, there were 2,251 adults in local institutions, of which 1,891 were diagnosed as mentally ill. In addition, 71 mentally defective children were confined in these institutions; of these, 34 were in the Halifax County Mental Home at Cole Harbour.(3)

The Nova Scotia Hospital serves as the admission unit through which a great majority of the patients are channeled for diagnosis and active therapy. If, after a period of observation and treatment, it is found that patients do not improve they are transferred to the local institutions for custodial care and brought back to the Nova Scotia Hospital for further active therapy as required.

The Nova Scotia Hospital is the teaching hospital for the medical faculty of Dalhousie University. Five psychiatrists of the university faculty serve as consultants in diagnostic and treatment work in the hospital. All modern treatment procedures are available, including a lobotomy service operated by the Victoria General Hospital.

Since 1951, the departments of psychology and psychiatric social work, occupational and recreational therapy have been considerably expanded although shortages of personnel still limit services, particularly in the field of occupational therapy.

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(1) Local Asylums for Harmless Insane Act, R.S. 1923, c. 53 as amended.

(2) Of these 11 institutions, 5 contained fewer than 15 mental patients.

(3) Report of the Inspector for Humane Institutions, 1952-53, pages 13-14.

New Brunswick. Until 1954, the provincial hospital at Lancaster was the only institution in New Brunswick which cared for the mentally ill. A new hospital - the provincial hospital, Campbellton - was opened on June 10, 1954, to serve the northern part of the province. The hospitals are under the executive direction of their superintendents who are responsible to the Director of the Mental Health Division, Department of Health and Social Services.

Treatment facilities in the hospital at Lancaster have been steadily expanded both through the purchase of equipment and the training and employment of additional personnel. In 1953, services included a 200 bed infirmary for the mentally ill, x-ray department, electroencephalographic section,(1) laboratory, facilities for insulin, electroshock and other therapies and a social service department. Electrocardiographic services and diathermy treatment are also available. The Social Service Department, staffed by three psychiatric social workers, carries out a heavy program of family interviews and cares for the social welfare of the patient

Quebec. Quebec has only one provincially operated mental hospital, the institution for mentally ill prisoners at Bordeaux. Accordingly, for most purposes, public mental hospitals have been closely affiliated with the departments of psychiatry of the three major universities, Montreal, McGill and Laval, not only for teaching purposes but also for general supervision and development of both in-patient and out-patient services.

The University of Montreal supervises the mental health program for french-speaking Montreal and the surrounding area and is closely linked with the Hopital Saint-Jean-de-Dieu, the Hopital de Bordeaux and with the psychiatric hospital, the Sanatorium Prevost.

McGill University supervises the administration of a variety of programs as well as the two institutions provided for english-speaking residents of Quebec. These institutions are the Verdun Protestant Hospital and the Allen Memorial Institute, a psychiatric teaching hospital which is an integral part of the Royal Victoria Hospital system.

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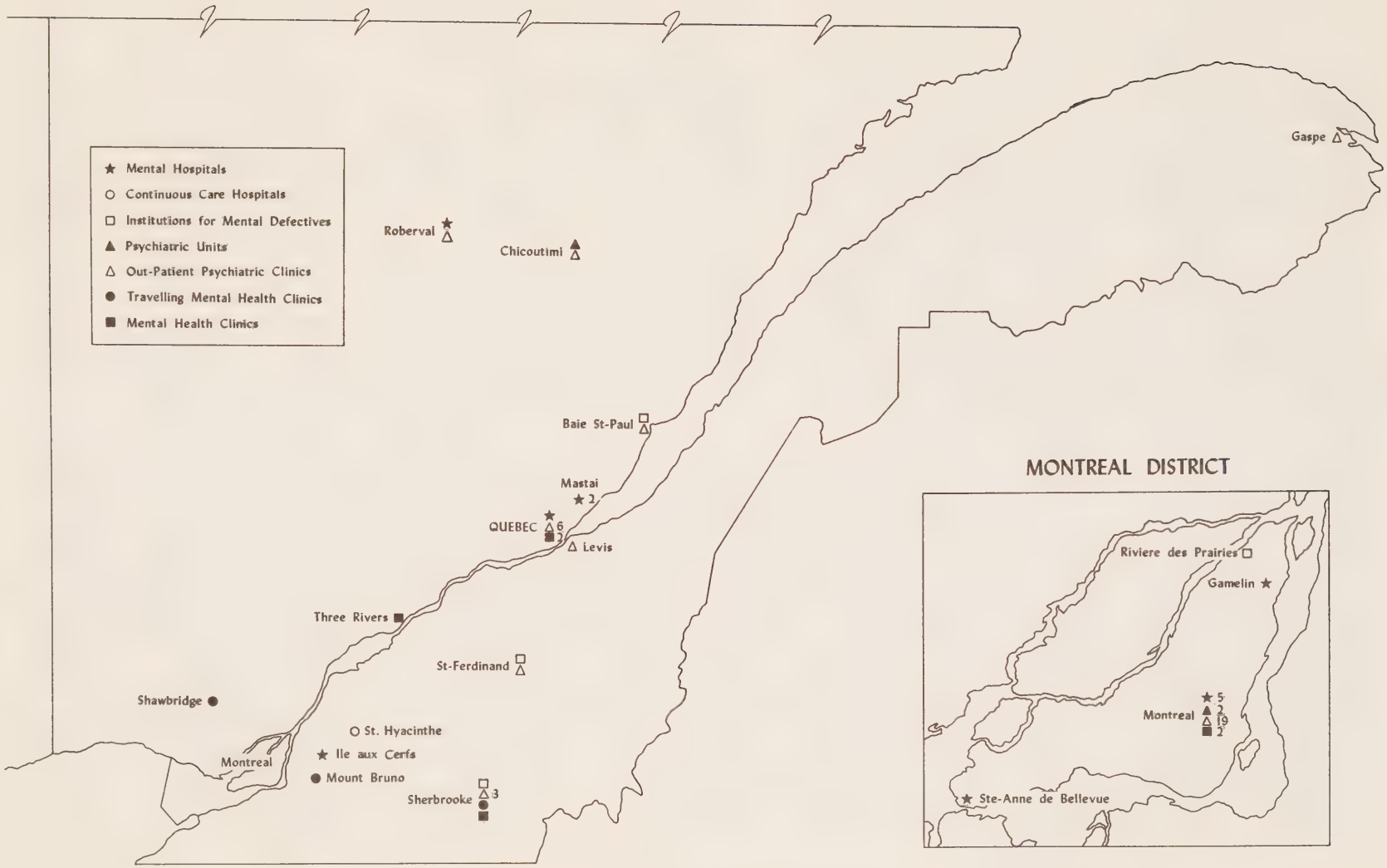
(1) Facilities of the electroencephalographic section are also used by the Saint John General Hospital.

QUEBEC



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Laval University directs the services designed for the population of Quebec City and the eastern part of the province. It is closely affiliated with the Hopital Saint-Michel-Archange and the adjacent psychiatric hospital, the Clinique Roy-Rousseau, as well as with the Hopital Sainte-Anne at Baie Saint Paul, the Hotel-Dieu-du-Sacre-Coeur de Jesus, the Hopital Saint-Julien, La Societe de Rehabilitation of Sherbrooke and the Hopital Sainte-Elizabeth which was opened in 1950.

Of the university-affiliated hospitals mentioned above, the following are discussed under "Mental Hospitals": Hopital Saint Jean-de-Dieu, Hopital de Bordeaux, the Verdun Protestant Hospital, Hopital Saint-Michel-Archange, Hopital Saint-Julien, and Hopital Sainte-Elizabeth. One institution for the mentally ill is not directly affiliated with a university - the Retrait Saint-Benoit in Montreal. The Allen Memorial Institute, the Clinique Roy-Rousseau and the Sanatorium Prevost will be described under Psychiatric Hospitals and the remainder in appropriate sections under services for mental defectives and epileptics.

University of Montreal: The Bordeaux Hospital is the provincial institution for both male and female psychotics and mental defectives who have been involved in criminal activity. Patients are sent from all courts and prisons in Quebec. After clinical examination they are either formally committed or sent back for sentence or for treatment at an out-patient clinic.

All classes of mentally ill and mental defectives, of most age groups, are found in this hospital. On March 31, 1953, there were 29 psychotic alcoholics, 15 psychotic epileptics, 57 psychotic mental defectives, 646 other psychotics and 91 mental defectives without psychosis. Fifty-five patients were in the 15 to 24 year age group and 73 were over the age of 65 (1)

Psychiatric treatment is given by visiting physicians and radiological, psychometric and biochemical services by consultants. A psychiatric social service is available to all patients coming to the hospital for diagnosis and to all resident patients before discharge. Families, employers, police and social service agencies in the patients' home city are interviewed to ensure that the patient is satisfactorily rehabilitated.

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(1) Quebec, Ninth Report of the Department of Health for 1952, 1954, pp. 92 - 93.

The Hopital Saint-Jean-de-Dieu is a teaching hospital of the University of Montreal. It is the largest mental institution in Quebec providing in 1953, accommodation for 4,082 psychotic patients, 1,446 non-psychotic mental defectives, and 393 other non-psychotic patients.(1) In addition to caring for all classes of mental illness the hospital admits all age groups. Of the 5,924 patients in residence 288 were under 14 years, 589 from 15 to 24 years, 4,289 from 25 to 64 years, 742 over 65 years and 16 of unknown age.

Substantial improvements have been made in the facilities of this hospital since 1945. Provincial and federal grants have enabled the institution to organize or expand treatment services including psychiatric and psychological care, lobotomy service, insulin and electroshock therapy, tuberculosis control and electro-encephalography. Departments of occupational and recreational therapy have been set up and social welfare workers interview patients and their families and attempt to place ex-patients in employment on discharge from hospital.

McGill University: The Verdun Protestant Hospital, a training hospital affiliated with McGill University, is located in Verdun on the Island of Montreal. This hospital is primarily an institution for adult psychotics; only 94 non-psychotics were in residence in 1953.(2)

Complete medical psychiatric as well as psychological, occupational and recreational therapy, and social welfare services are provided. Since 1949, increases in staff have made possible an expansion of psychiatric and other therapeutic programs. Staff additions have included 4 psychiatrists, 1 director of psychiatric social services and 1 senior resident physician, all full-time and 3 psychologists who work part-time.

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(1) Psychotic patients include alcoholics (59), epileptics (249), seniles (117) and mental defectives (260). Non-psychotic patients include simple epileptics (20), mentally defective epileptics (190).

(2) Of the 1,589 psychotic patients in the hospital, 39 were alcoholics, 45 were epileptics, 79 were seniles and 111 mental defectives.

Laval University: The Hopital Saint-Michel-Archange at Mastai, near Quebec City, is one of the oldest mental institutions in Canada. Closely integrated with it is the Clinique Roy-Rousseau, a neuro-psychiatric hospital which is situated adjacent to the larger institution. Both the Clinic and the Hospital are integrated with the program of Laval University, whose Professor of Psychiatry serves as medical director of the Hospital. Other faculty members similarly extend services. Other units of the Hospital are The Ecole La Jemmerais, a training school for mentally defective children, and the Pavillon Dufrost, a separate building for the aged mentally ill and other patients who are not amenable to treatment.

This institution cares for both psychotic and non-psychotic patients of all ages. In 1953, there were 1,052 non-psychotic patients, of whom, 730 were mental defectives, 88 were mentally defective epileptics, 41 were simple epileptics and 4 alcoholics. Of the 3,373 psychotic patients, 219 were mental defectives, 85 were epileptics and 40 alcoholics.(1)

Facilities are available for a complete program of services - electroshock, insulin and psychotherapy, speech therapy, social services, electroencephalography, radiology, biochemical analyses and medical psychiatry. In addition it has a chemical research laboratory and a training school for nurses. Social Services are under the direction of a psychiatric social worker. All applications for admission are investigated; follow-up work is done with patients who are discharged or transferred to other units. Since 1949, there has been a substantial increase in the number of medical personnel in the hospital including 11 additional psychiatrists, 3 physicians and 15 psychiatric nurses.

The Hopital Saint-Julien at Saint-Ferdinand, owned by a religious order, was rebuilt in 1933. In 1954, it consisted of a 6 storey building with 2 wings and separate buildings for workshops. The hospital also operates a large farm.

This institution admits all classes of female patients of all ages but cares primarily for mental defectives. In 1953, there were 649 non-psychotic and 291 psychotic patients in residence. Of the former,

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(1) In 1953, there were 32 patients under 14 years, 441 between 15 and 24 years and 534 over 64 years.

597 were mental defectives and 27 were epileptics; of the latter, 21 were epileptics and 51 mental defectives. There was also a large number of younger patients in residence; 220 were under 15 years, 218 between 15 and 24 years and 98 over 64 years. Treatment is provided by physicians in regular attendance and specialist medical services are available when needed. Surgical, laboratory, x-ray and physiotherapy services have been expanded since 1949.

The Hopital Sainte-Elizabeth at Roberval was opened in 1950. This institution for the mentally ill has a population almost equally divided between the mentally ill and the mentally defective. Many of the patients, especially those in need of custodial care whose homes are in the Roberval area have been transferred from Saint-Michel-Archange. The hospital is under the supervision of a medical director who is a part-time employee and supplements its in-patient medical services by utilizing outside consultants. Surgical, radiological, x-ray and laboratory services are operated in the hospital.

In May, 1953, there were 684 patients in residence; 328 psychotic and 356 non-psychotic patients. Three hundred and thirty non-psychotic patients were mental defectives and 12 were epileptics; 27 psychotic patients were mental defectives, 15 were senile and one was epileptic. Eleven patients were under 14 years, 138 were in the 14 to 25 year range, and 40 were over 64 years.

The Retraite Saint-Benoit is the only reported public hospital for the mentally ill which is not affiliated with a university. This hospital cares for continued care cases as well as for the mentally ill. In March, 1953, only 105 mentally ill patients were reported. Of these, 76 were psychotic; the 29 non-psychotics were chiefly mental defectives. Most of the patients were adults in the 25-65 age range; none was under 15 years.

Ontario: For purposes of exposition, mental hospitals have been grouped according to hospital regions as outlined in the Ontario health survey report.

South-Western Ontario. There are three mental hospitals in this region: the Ontario Hospital, London, the Ontario Hospital, St. Thomas, and the Ontario Hospital, Woodstock.

ONTARIO

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The Ontario Hospital, London, generally provides care and treatment for psychotic patients of both sexes. On December 31, 1952, there were 1,590 patients in residence of whom 1,439 were psychotic. Of the 151 non-psychotic patients, 137 were mental defectives, 8 were alcoholics and three were mentally defective epileptics. In addition, 33 patients resided in approved homes. All, except 10 patients were over twenty years of age and 443 patients were over sixty-four years.(1)

This hospital is one of the teaching hospitals of the University of Western Ontario Faculty of Medicine. The Professor and Head of the Department of Psychiatry at the University also serves as Superintendent of the hospital, which supplements its resident medical personnel by purchasing the services of medical specialists and consultants from London.(2)

Modern treatment services are available including electroshock, insulin coma therapy and a leucotomy program. Occupational and recreational therapies have been expanded in the last few years and an after-care and rehabilitation service established for follow-up work with patients discharged from hospital.

The Ontario Hospital, St. Thomas, is the largest mental hospital in Ontario. In 1952, there were 1,943 patients of both sexes in residence of whom 1,673 were psychotic and 270 non-psychotic.(3) Over one-half of the psychotic patients were diagnosed as schizophrenics (1,030); in addition, there were 14 alcoholics and 18 epileptics. Of the non-psychotic patients 222 were mental defectives, 4 alcoholics and 6 epileptics. The hospital cares primarily for adult patients; only 77 patients were in the 15 to 24 year age group, while 365 were over 64 years.

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(1) Ontario Mental Hospitals and Mental Health Services, 1952.

(2) The National Health Program has enabled the Provincial Government to expand its post-graduate training in the Ontario Hospitals' Service leading to eligibility for certification by examination in the specialty of Psychiatry by the Royal College of Physicians and Surgeons (Canada). Nearly all Ontario Hospitals have benefitted from the services of these physicians.

(3) Some patients are maintained in approved boarding homes where they are supervised by the Social Work Department.

Psychiatric treatment is provided by a staff of resident physicians. Specialist medical staff, mostly from the University of Western Ontario Medical School, provide services on a consultant basis. Treatment services included a geriatric unit of 400 beds in 1952; insulin therapy, electroshock therapy, psychology, leucotomy and x-ray services. An occupational therapy department has been in operation for some time and a recreational service was established in 1952. Social workers maintain contact with ex-patients and also form a part of the team of the travelling clinic which serves the area surrounding St. Thomas.

The Ontario Mental Hospital, Woodstock, provides accommodation for epileptics and tuberculous mental patients. The hospital consists of a separate Chest Diseases Unit and an Epilepsy Unit, both of which have extensive medical, rehabilitation and social services. Patients are admitted from all Ontario Hospitals. In 1953 there were 592 epileptics and 590 tuberculous cases in residence. Of the epileptics, 86 were uncomplicated cases, 151 were also psychotic and 361 were also mentally defective; 117 of the tuberculous cases were mentally defective.

The leucotomy program and other special surgical work are carried out in local general hospitals Consultant and specialist services are supplied by outside physicians.(1)

Hamilton and the Niagara Peninsula The Ontario Hospital, Hamilton, provides care mostly for psychotic patients, although in 1952, 145 mental defectives were in residence. Patients of both sexes over the age of 15 are admitted; in 1953 the population consisted of 64 patients between 15 and 24 years, 1,125 patients in the 25 to 64 year range and 522 patients over 64 years.

In-hospital medical services are extensive and are supplemented by regular visits from specialists and general practitioners. Extensive surgical services including leucotomies, insulin and electroshock therapies, occupational and recreational therapies and social work are all separately organized.

Central Ontario. The Ontario Hospital, Toronto is closely linked with the Toronto Psychiatric Hospital, many of whose medical staff provide part-time services.

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(1) See, "Services for Epileptics".

The hospital treats mostly adult psychotic patients and, in 1952, its population included only 64 non-psychotics.(1) A substantial number of elderly patients were in residence: 386 out of 1,260 patients were over 64 years.

Medical services are expanding steadily. Insulin shock treatment was commenced in 1952; other services include electroshock therapy, psychotherapy, electroencephalography, and a leucotomy service.(2) An extensive psychological service is also maintained. Recreational and occupational therapy is available and a social service section assists with interviewing patients and follow-up of ex-patients.

Like the Ontario Hospital in Toronto, the Ontario Hospital, New Toronto, co-operates very closely with the Toronto Psychiatric Hospital. The hospital population in 1952 was predominantly psychotic (1,376)(3) with only 144 mental defectives in residence. There were fewer patients over the age of 64 in this hospital than in the Ontario Hospital, Toronto, but considerably more in the age 15 to 24 age group. One hundred and thirty-seven patients resided in approved homes under the supervision of the hospital Social Welfare Service. Treatment services are similar to those described above. Medical specialists visit the hospital weekly and a consultant staff is available.

The Ontario Hospital, Whitby, also is essentially for psychotic patients.(4) The standard of medical care has improved in recent years. More resident psychiatrists have been employed, the surgical service has been

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(1) Non-psychotic patients included 44 mental defectives, 6 epileptic mental defectives, 5 epileptics and 1 alcoholic.

(2) The leucotomy service is carried on in conjunction with the Toronto Psychiatric Hospital and the Toronto General Hospital, the operations being performed at the General.

(3) On December 31, 1952, there were 25 psychotic alcoholics in this institution.

(4) On December 31, 1953, there were 1875 patients in residence, of whom, 119 were non-psychotic. The population included 19 non-psychotic alcoholics and 27 psychotic alcoholics. Twenty-one per cent of the patients were over 64 years and 75 per cent between 25 and 64 years. Over 200 patients from this hospital are boarded out in approved homes under constant supervision.

extended, x-ray, electroencephalography and insulin-coma departments have been either improved or established and a consultant and visiting specialist staff engaged. A psychology service is in operation and since 1949 the number of occupational therapists have been doubled.

The Ontario Hospital at Langstaff, is situated on a hospital farm, where male continued care cases, able to work, are employed in the fields and gardens. Necessary treatment services are provided by the hospital staff, local general practitioners and a consultant staff. On December 31, 1952, out of a population of 498 patients, 89 were simple mental defectives and 33 defectives with psychosis.(1)

The Ontario Hospital, Cobourg, provides treatment and care for both psychotic and non-psychotic female patients. At the end of 1952 over 25 percent of the patients were hospitalized because of schizophrenic disorders while over 60 per cent were non-psychotic mental defectives. Over 20 per cent were 65 years of age or more. Medical treatment including electroshock is available for psychotics; a psychological service is available to everyone. General practitioners, visiting specialists and consultants provide most of the medical services. Full-time occupational therapists and a psychiatric social worker are also employed.

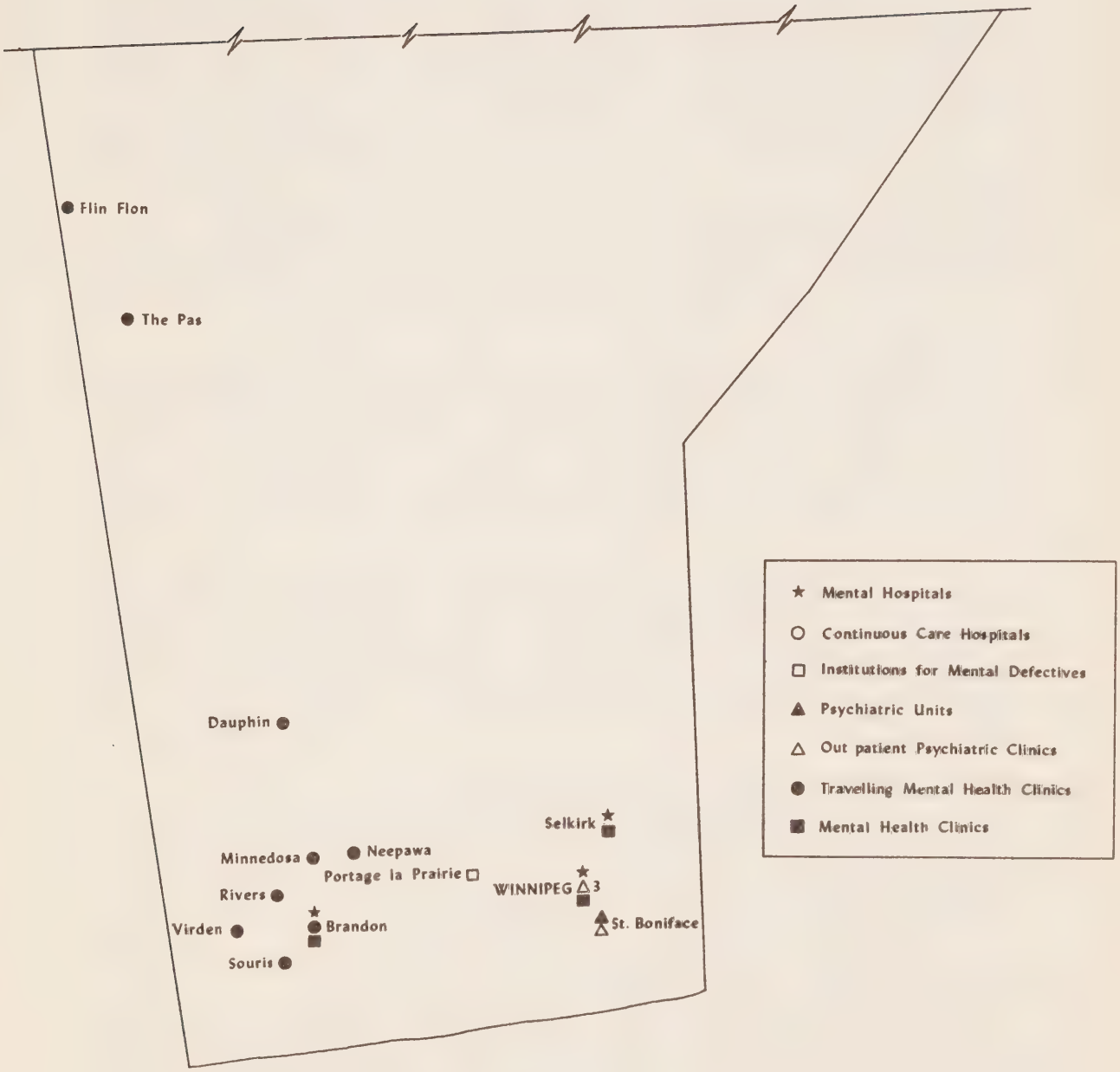
The Ontario Hospital at Penetanguishene consists of two widely separated divisions: one for mentally ill prisoners and one for psychotics and mental defectives. In-hospital medical treatment services provide electroshock therapy while visiting specialists and consultants provide other medical treatment

East-Central Ontario. The Ontario Hospital, Kingston, is a teaching hospital for medical students from Queen's University. Although it is maintained primarily for psychotic patients, accommodation is also available for some adult mental defectives

A large part of the medical service is provided by a consultant staff. All major surgery, other than brain surgery, is performed in the hospital by a consultant surgeon, but brain surgery is carried out at the Toronto General Hospital. Electroshock treatment and electrocephalographic services are available and in 1953 a limited psychotherapy service was begun. The

(1) Of 498 patients, 20 were between 15 and 24 years of age, 409 between 25 and 64 years and 69 over 64 years.

MANITOBA



Research Division, N. H. & W.

psychology department carries out psychometric testing and research into group therapy. Occupational and recreational therapy departments are also in operation.

Eastern Ontario. The Ontario Hospital at Brockville provides accommodation and treatment for psychotic patients (1) from Eastern Ontario, including the City of Ottawa. In 1952, over 20 per cent of the residents were over 64 years of age. The hospital was built on a cottage plan, and various classes of patients are segregated. Since 1952 new cottages have been added and the older ones renovated. Over a hundred patients are boarded out in approved homes.

In 1952, medical treatment services were extended by the addition of an insulin coma and electroshock therapy unit. Specialists visit the hospital at intervals and consultant medical services are provided.

Northwestern Ontario. The needs of the population in Northwestern Ontario are met by the Ontario Hospital at Port Arthur. A small division of this hospital used to be maintained at Fort William but is now (1954) being replaced by a large hospital at Port Arthur. On December 31, 1953, there were 120 male patients in residence - 103 psychotics and 14 mental defectives.

Manitoba: Of Manitoba's four mental institutions, only two provide extended care for the mentally ill: the Hospital for Mental Diseases in Brandon and a second by the same name at Selkirk. Both are provincially owned and administered, and each is headed by a medical superintendent, responsible for the organization and program of his hospital

Hospital for Mental Diseases, Brandon. The Brandon hospital which serves the western and northern parts of Manitoba has complete facilities for diagnosis, treatment and continued care for every class of mental case. The general organization of the hospital divides it into four parts: (a) The Male Psychiatric Institute which admits epileptics and syphilitics as well as psychotics. Facilities are available for modern therapy including insulin and electric shock treatment; since 1952, the majority of insulin cases have also been given group psychotherapy. (b) The Female Psychiatric Institute which provides services similar to those of the Male Psychiatric Institute. (c) The Male Infirmary, and (d) The Female Infirmary, which together constitute the

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(1) A few non-psychotic adult patients are in residence in this institution, including 75 mental defectives.

hospital section for treating physical ailments. It also has a tuberculosis unit which cared for 39 patients in 1952.

Several separate departments provide special services: the x-ray department gives routine admission chest x-rays for the control of tuberculosis to both staff and patients; an electroencephalographic department is directed by a part-time director consultant; electroencephalograms are taken of all epileptics, both in the interests of diagnosis and research (in 1952, E.E.G.'s were taken of 83 epileptics). A leucotomy service, under the direction of a consulting surgeon, began operation in 1949; in 1952, 42 leucotomies were performed on patients resident in the two Psychiatric Institutes. A Recreational Therapy Department maintains an activity program including sports, dramatics and occupational therapy.

The major problem of this hospital has been and continues to be overcrowding and a shortage of skilled personnel. In 1952, the shortage of qualified nurses was so acute that untrained personnel had to be used on the wards; thirty graduate nurses were needed.(1) A program designed to alleviate this shortage through in-hospital training is discussed elsewhere.(2)

Hospital for Mental Disease, Selkirk. Since 1886 the Selkirk hospital has served the Greater Winnipeg area, the Red River Valley, the Interlake District and Eastern Manitoba. Due to its proximity to metropolitan Winnipeg, overcrowding has been greater than at Brandon.

Hospital services for all classes of patients are organized and supervised by a medical superintendent and assistant superintendent. General services include routine physical examinations, dental examinations twice yearly and chest x-rays once a year. Insulin-coma and electric shock therapy are in use and a leucotomy service performed 34 operations in 1952. Psychometric tests are available, as needed.

An activities director is in charge of the Occupational and Recreational Department. Occupational therapy is given to all female patients but, due to lack of space, this has had to be limited to the male patients in the reception centre. Training includes

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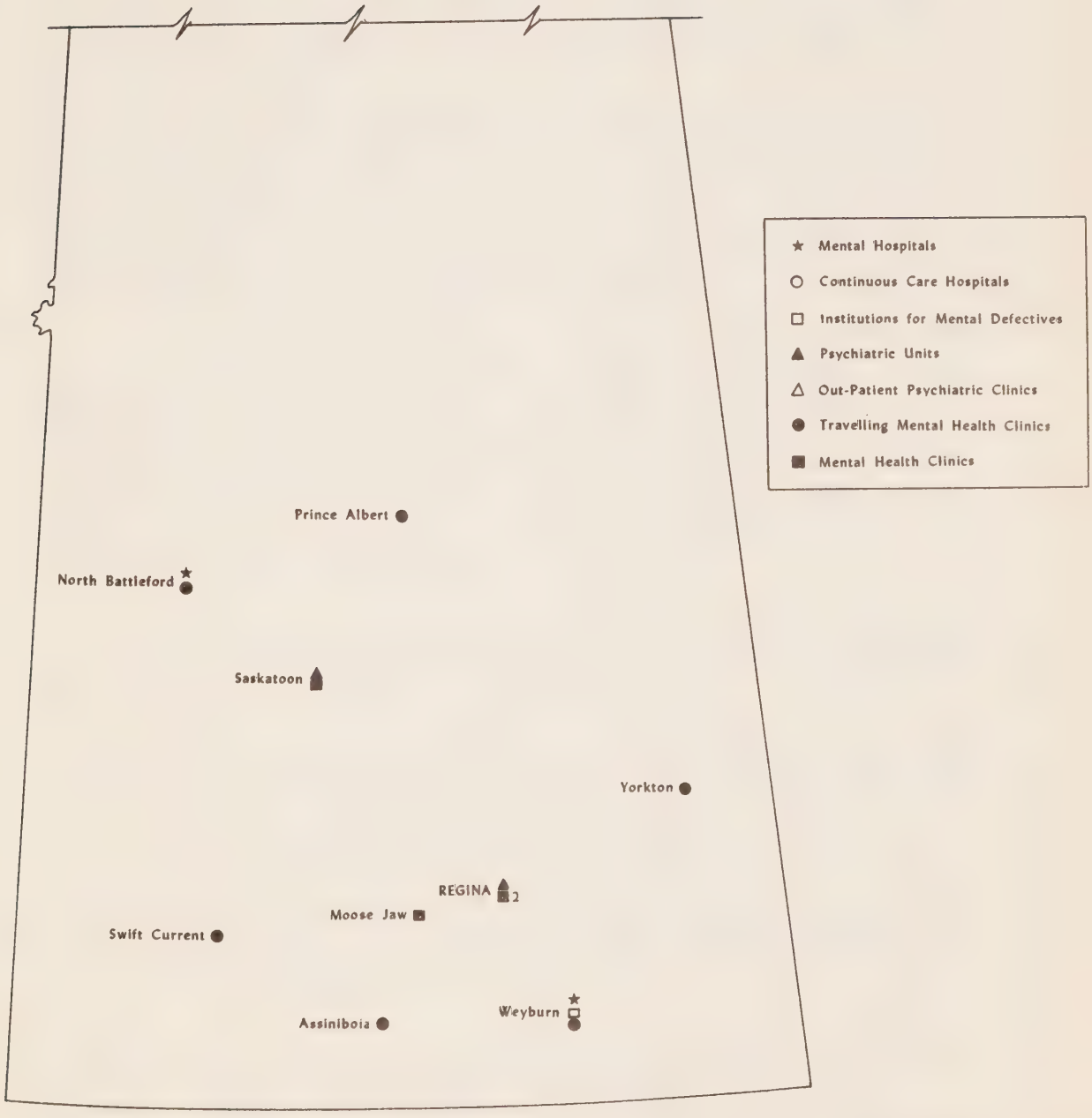
(1) Annual Report, 1952, p. 171.

(2) See section, "Mental Health Personnel".

SASKATCHEWAN



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hairdressing and sewing and, for some patients, work on the hospital farm. A local voluntary organization, SHARE, has assisted greatly with recreation in this hospital.

A social worker who calls on patients and their relatives assists with rehabilitation work. Close co-operation is maintained with welfare agencies and employment services.

Saskatchewan: Free treatment for hospitalized patients and the province's traditional policy of "no waiting lists"(1) have resulted in a very large in-patient population in Saskatchewan's mental hospitals. Despite overcrowding, substantial progress has been made in providing treatment services for patients; the program now includes all modern forms of therapy.

The Saskatchewan Mental Hospital, Weyburn, provides accommodation for all classes of patients. Electroshock therapy, psychotherapy, insulin coma therapy and psychometric testing are available for all patients needing active treatment. A substantial number of patients in this hospital are unable to respond satisfactorily to active treatment. Continued care cases are maintained in separate wards and a special program has been established.

The hospital maintains departments of occupational and recreational therapy and, with voluntary assistance, is steadily developing a program of patient activity.

The Saskatchewan Hospital, North Battleford, also provides modern treatment; insulin coma, electroshock for both the acute mentally ill and for patients in need of continuous care, an electroencephalographic service, leucotomy service and psychological testing are among therapies available. A geriatrics unit has been established in a separate building with special services for seniles. Psychiatric social work, occupational and recreational therapy are organized as separate departments of the hospital.

Alberta: Prior to 1948, the Provincial Mental Hospital at Ponoka was the only active-treatment centre in Alberta. Since the inception of the National Health Program, however, the mental institution at Edmonton, which was formerly a continuous care hospital, has been converted to active treatment through the provision of additional facilities and specialist services.

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(1) Saskatchewan Health Survey Report, Volume One, Health Programs and Personnel, 1951, p. 89.

The Provincial Hospital at Ponoka serves as the chief diagnostic centre for the mentally ill but there is a considerable interchange of patients among all Alberta institutions. A patient may be admitted to Ponoka for diagnosis and, if his condition warrants, may be sent on to Claresholm or Raymond Auxiliary Mental Hospitals or to the training school at Red Deer. The hospital cares primarily for psychotic patients.

Facilities and services at Ponoka have been expanded considerably during the last six years. A clinical director (graduate in psychiatry) has been appointed to supervise treatment services including electro and insulin shock and psychotherapy. The hospital provided some occupational therapy before 1948; however, in 1950, a special building was erected to house the occupational and recreation therapy departments. Equipment was purchased and instructors provided for a wide variety of crafts. Two recreational therapists have also been employed. On the surgical side, all operations under the Sexual Sterilization Act of the province are carried out in this hospital.(1) A limited number of lobotomies are also performed.(2) An instructor has been engaged to provide re-education for post-lobotomy cases

In mid-1949, a psychiatrist was appointed as Clinical Director of Medical Services at the Provincial Hospital in Edmonton and plans for converting the hospital to an active treatment centre were implemented. The hospital, which is chiefly for psychotics,(3) was equipped to treat this class of patient

Services provided include electro and insulin shock therapy and psychotherapy. An electroencephalographic service is available and in 1950, children began to be admitted for observation and treatment. Few, if any, leucotomies were performed prior to 1952; however, surgical services in general were extended at that time with the provision of surgical equipment and leucotomies are now performed by University of Alberta surgical staff.

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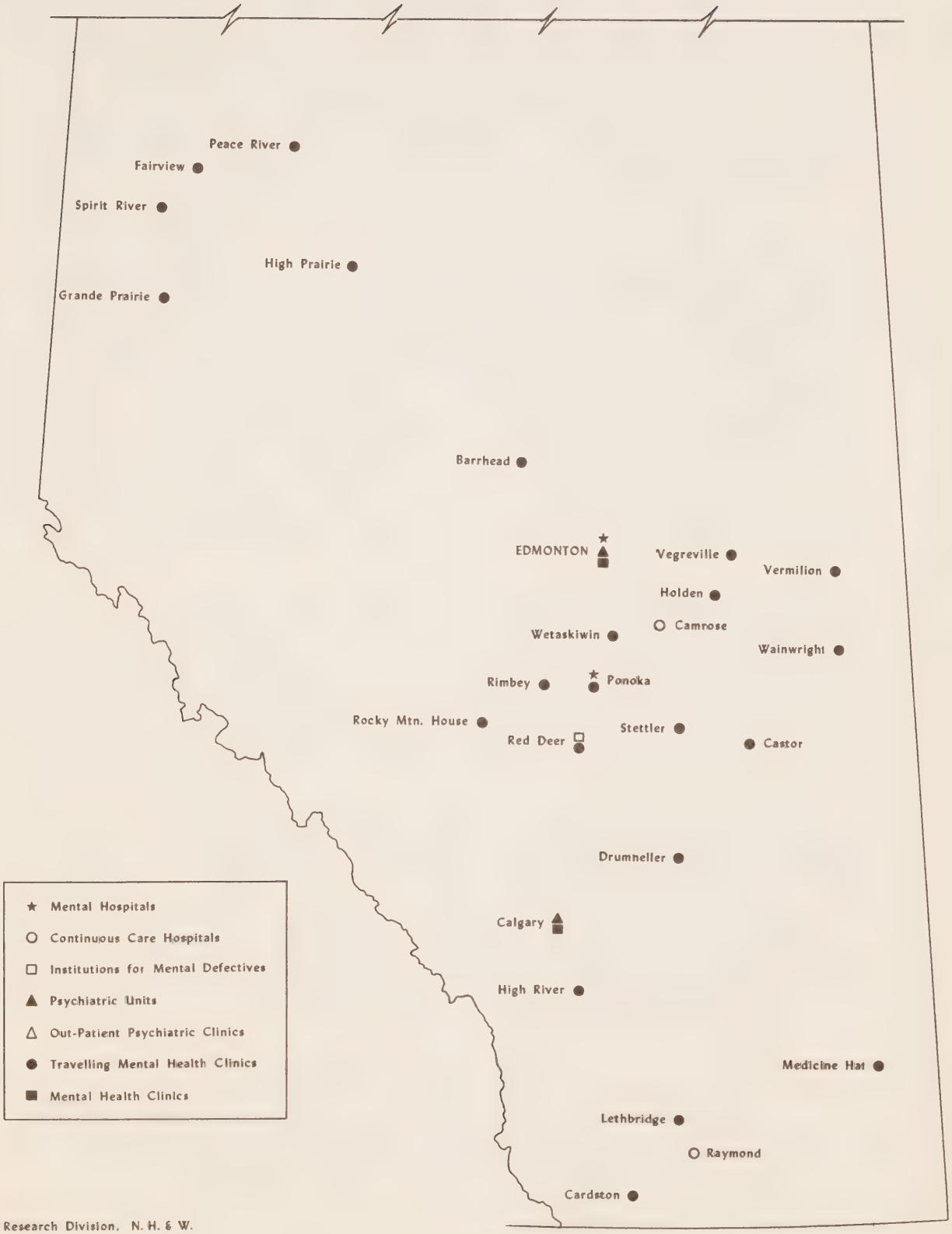
(1) In 1950, 67 operations were performed.

(2) In 1951, 26 leucotomies were also performed by a surgeon from outside the hospital.

(3) In December, 1951, there were 981 patients in residence; of these, 4 were simple epileptics, 24 epileptic mental defectives, 153 non-psychotic mental defectives and the remainder psychotics.

ALBERTA



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Non-medical services include psychometrics, occupational and recreational therapy and social welfare work. The single clinical psychologist for the psychometrics program was employed in 1952.(1) The social worker was engaged specifically to work in the rehabilitation area. Occupational therapy was begun in 1948, and has been expanded since that time. Both occupational and recreational programs have a full schedule of activities. Other Alberta mental institutions lack treatment facilities and are designed to offer mainly custodial care for cases in need of continuous care.

British Columbia. Institutions which provide active treatment for the mentally ill in British Columbia include the Provincial Mental Hospital at Essondale and the Crease Clinic of Psychological Medicine, a psychiatric hospital so closely associated with the adjacent mental institution that it becomes impossible to discuss their treatment facilities separately.(2) In addition to these, the Provincial Mental Home for the Criminal Insane cares for a specific group of the mentally ill.(3) While the Homes for the Aged at Vernon, Port Coquitlam and Terrace form an integral part of the province's mental health program, they lack active treatment facilities.

In March, 1953, the Provincial Mental Hospital at Essondale reported a resident patient population of 3,419 as opposed to a total of 994 in the three Homes for the Aged. Essondale is the admission and diagnostic centre for the province; all patients are screened at its reception centre; seniles may be transferred to a Home for the Aged and mentally ill prisoners to the Colquitz institution.

The mental hospital proper consists of several independent units including the reception centre already mentioned, a building for acute cases, "continued treatment" centres for men and women and a 295 bed veterans' unit at the Colony Farm. A 230 bed hospital unit for tuberculosis cases is under construction and is expected to be completed in 1955. The Crease Clinic, opened in 1950, is situated on adjoining property.

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(1) This position was vacant in 1953.

(2) See also "Psychiatric Hospitals".

(3) This will be discussed under the section, "Forensic Psychiatric Services", p. 155.

All treatment activities within the Essondale area (including the Clinic) are supervised by one clinical director. Departments of pathology, neurology, radiology, psychology, nursing, social service and rehabilitation have been organized and treatment programs demand a close integration of the work of all of these. A number of specialist consultants are employed by the Mental Health Services of British Columbia, including a neurosurgeon, general surgeon and orthopaedic surgeon.

All modern forms of therapy are provided - insulin, electro-convulsive shock, electro-narcosis, lobotomy, psychotherapy, occupational and recreational therapy and others. Individual psychotherapy is used extensively and group psychotherapy in the women's rehabilitation ward, the women's lobotomy ward, the men's alcoholic ward, adolescent patients' ward and for patients receiving insulin coma treatment. A reactivation program (involving an attempt to improve the patient's social motivation) is also being tried.

An alcoholics' clinic was opened at the mental hospital in 1952.(1) A Geriatric Division with branches at Port Coquitlam, Vernon and Terrace looks after the treatment of ageing persons with degenerative disease.(2)

The Social Service Department of the hospital is uniquely organized. Psychiatric social service personnel in both the mental hospital and the clinic are appointed by the Social Welfare Branch of the provincial Department of Health,(3) but, once employed, are under direct authority of the administrative heads of the provincial Mental Hospital Services. Direct links retained with the Social Welfare Branch concern policies relating to overall personnel allocation and standards of work performance. Case work activities are under the immediate direction of a provincial Supervisor of Psychiatric Social Work.

In 1953, 9 psychiatric social workers were on the mental hospital staff and 8 with the clinic. Staff are divided into 3 groups to handle admission cases and continued treatment cases and rehabilitation. The

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(1) See Section, "Services for Alcoholics".

(2) See section, "Services for Seniles".

(3) This applies to psychiatric social workers at the Woodlands School and the Child Guidance Clinic also.

BRITISH COLUMBIA

Research Division, N. H. & W.

first group concentrates on creating in patient and family an understanding and acceptance of the need for treatment.(1) Of the second group, two social workers began full-time work on the wards in 1952-53 with the purpose of developing greater social consciousness among the patients. The third group assists with re-establishment of patients about to be discharged.

The provincial government maintains a home, the Vista Rehabilitation Home, for female patients discharged from either the hospital or the Crease Clinic. Its purpose is to provide temporary lodging for those who need it during the interim between discharge and rehabilitation into community life. It accommodates about 7 persons.(2) The average duration of stay is two or three weeks or until employment is secured. Members of the Social Service Department continue contacts made with patients before discharge and assist with readjustment. The Supervisor of the Vista is responsible for job placement.

A rehabilitation job placement service is provided for male patients, but no residence. The Y.M.C.A. and the Salvation Army Hostels in Vancouver have both co-operated in lodging selected ex-patients.

PSYCHIATRIC HOSPITALS

The psychiatric hospital differs from the mental hospital in that it is designed to provide intensive short-term treatment only for patients with a favourable prognosis. Duration of hospitalization is limited by statute in some provinces and in all provinces, cases requiring prolonged care are transferred to the mental institutions. Most of the psychiatric hospitals in Canada are affiliated with major universities, are closely integrated with the universities' training and research programs and are served by various professional personnel from the university staffs.

The seven Canadian institutions classified as psychiatric hospitals include the Clinique Roy-Rousseau,

(1) In 1952-53, 39 per cent of admissions to the hospital and 47 per cent of clinic admissions received such help.

(2) During 1952-53, 58 patients were admitted; of these, 39 were rehabilitated to an outside job and lodging, 6 to the community and 9 to their homes. Four were returned to the hospital.

the Sanatorium Prevost and the Allen Memorial Institute in the province of Quebec, the Toronto Psychiatric Hospital in Ontario, the Winnipeg Psychopathic Hospital in Manitoba, the Munroe Wing of the Regina General Hospital in Saskatchewan and the Crease Clinic of Psychological Medicine in British Columbia.

In the following discussion, no attempt is made to distinguish between psychiatric hospitals which operate in independent buildings and those which are housed in a hospital wing. They have been arbitrarily grouped in this discussion because, regardless of location, the resources available and the services rendered to the public have much in common.

Clinique Roy-Rousseau. Quebec City

The Clinique Roy-Rousseau is a neuro-psychiatric institute adjacent to the Hopital St-Michel-Archange in Quebec City. It is closely affiliated with Laval University and serves as a training centre for students specializing in neuro-psychiatry. A limited number of neurological and psychiatric cases are admitted.(1) The Clinique works in close co-operation with the neighbouring mental hospital and has access to all of its medical specialties and laboratory facilities. Complete diagnostic and treatment services are available. Social workers maintain case histories, interview families and do follow-up work with discharged patients.(2)

Sanatorium Prevost: Montreal

The Sanatorium Prevost is a private, lay hospital operated exclusively for psychiatric patients with favourable prognosis.(3)

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(1) In 1952 the Clinique reported 89 new admissions and 9 readmissions.

(2) Because only partial data are available on the number of personnel employed by the psychiatric hospitals, reference to staff paid through the Mental Health Grant has been omitted since it would only distort the picture. However, most mental health services have expanded their staffs through federal grant aid

(3) The hospital claims that it is a non-profit organization. No evidence is available concerning finances, but the hospital accepts indigents under the Quebec Public Assistance Act. Approximately 10 out of the 52 beds are reserved for indigents admitted from the out-patient clinic

Complete psychiatric treatment facilities are available. These include facilities for insulin and electroshock therapy, psychotherapy, an electroencephalographic service, psychometrics and social welfare care. In 1951, the medical staff numbered 8 psychiatrists and neuropsychiatrists and 15 consultants, including the senior Professor of Neurology from the University of Montreal.

Allen Memorial Institute

The Allen Memorial Institute, opened in 1944, is a psychiatric teaching and research centre closely integrated with the Royal Victoria Hospital and McGill University. Since the new wing was opened in November, 1953, it provides bed accommodation for 93 in-patients as well as an out-patient clinic limited to ex-patients of the hospital.(1) Consultative, diagnostic and treatment services are available to applicants from anywhere in Canada or abroad. During 1952 alone, 20,000 patient days of treatment were given.

The recent addition to the building has a fully self-contained treatment unit equipped to operate independent of the rest of the hospital in case of air attack or other emergency. The several hospital departments are completely equipped and staffed to provide all types of therapy. In addition to facilities available at all of the psychiatric hospitals, an Alcoholic Centre gives psychotherapy and antabuse treatment to alcoholics and a Gerontological Centre has been established to explore the social, psychological and somatological problems of the aged. The Electroencephalography Department also has a well-equipped research laboratory.

Psychiatric personnel serve both the Allen Memorial Institute and the Royal Victoria Hospital.

The Toronto Psychiatric Hospital

The history of the Toronto Psychiatric Hospital dates back to 1908 when a Royal Commission was appointed by the Ontario Government "to visit European hospitals, to collect information and to submit a report with recommendations for the building of a hospital in

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(1) The public out-patient clinic is held at the Royal Victoria Hospital but is staffed by personnel from the Allen Memorial Hospital. Its services are described elsewhere.

Toronto".(1) It was not until 1921, however, that plans to build were implemented and the first patients were received in 1926. The hospital, built on property owned by the University of Toronto, serves as a teaching and research hospital for that institution.

The Toronto Psychiatric Hospital is operated under the Psychiatric Hospitals Act of 1926 which limits its services to persons resident in greater Toronto.(2) Roughly 2,500 out-patients and 600 in-patients receive treatment each year. Persons certified as mentally ill, mentally defective, epileptic or "chronically" disturbed are not admitted.

Facilities are available for all types of modern therapy. An average of 50 leucotomies are performed yearly.(3) The Department of Forensic Psychiatry works with cases from both juvenile and adult courts (4) The social work department participates actively in the training of psychiatrists, psychologists and nurses. Other inter-disciplinary approaches to training have been initiated in co-operation with the university and considerable development has been made in the establishment of a child guidance program involving personnel from the various disciplines. Emphasis is placed on follow-up work with ex-patients

The Winnipeg Psychopathic Hospital

The Winnipeg Psychopathic Hospital was established in 1919 through an agreement between the provincial government and the Winnipeg General Hospital. A 38 bed unit was set aside to provide diagnostic and short-term care for psychiatric cases from Greater Winnipeg and the

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(1) Ontario Hospital Division. Ontario Hospitals for the Mentally Ill, Mentally Subnormal and Epileptic: Sixty-fifth Annual Report, 1932, p. 100.

(2) Although the Act limits the hospital's services to residents of the greater Toronto area, there is no evidence that this principle is adhered to in practice.

(3) In 1950-51, 52 operations were performed and from January 1, 1951 to March 25, 1952, another 52 operations.

(4) See section "Forensic Psychiatric Services", page 155.

E R R A T U M

MENTAL HEALTH SERVICES IN CANADA

Page 24; Table II - title should read

Total Admissions to Card-Reporting Mental Institutions: By Method of Commitment, 1946-1952.

Page 43; footnote 4 - should read

From 1946 to 1952 total admissions to card-reporting mental institutions rose from 11,000 to nearly 16,000. Total admissions to all mental institutions rose from 12,896 to 23,131. See Dominion Bureau of Statistics, Mental Health Statistics, 1953, Ottawa, 1954.

Page 45; line 32 - should read

(2) completed accommodation for 6,382 beds

Page 45; line 33 - should read

were constructing accommodation for 5,397 beds

Page 45; line 34 - should read

-cated in Table VI. Of the 11,779 beds completed or in

Page 45; line 35 - should read

-the course of construction, 4,779 beds were in mental

Page 46; Table VI - Accommodation under construction in the province of Nova Scotia - For 340 read 568; accommodation under construction, 1954, in Canada - for 5,169 read 5,397

Page 47; Table VII - Number of Beds in Nova Scotia Mental Hospitals - For 552 read 780. Number of beds in Canadian mental hospitals - For 4,571 read 4,779. Total Number of Beds in Nova Scotia - For 616 read 844. Total number of beds in Canada for 11,551 read 11,779

surrounding area.(1) It is an integral part of the provincial psychiatric services and the director of the provincial Division also serves as superintendent of the hospital.

The government purchases services such as cleaning, heating and lighting facilities, food, nursing and ward staff care from the Winnipeg General Hospital. The general hospital also provides laboratory facilities including bacteriological, pathological and biochemical analyses, cardiography, electroencephalography, pneumoencephalography, and x-ray services. All drugs are supplied through the general hospital; operating theatre facilities and specialist consultation are also purchased from this source. The provincial government pays all costs on a per capita, per diem basis.

Complete medical treatment is available for both organic and functional diseases. The permanent medical staff is engaged and paid by the province.

During their relatively brief hospital residence a number of patients receive occupational therapy. A large volume of work is carried by the Social Service staff, especially in relation to home visits and follow-up work with discharged cases.

During past years it has been customary to channel many of the patients who ultimately go to the mental hospital at Selkirk and some who go to the Brandon institution through the Winnipeg Psychopathic Hospital for diagnosis. Attempts are now being made to arrange direct admission to the mental hospitals.

The Munroe Wing, Regina General Hospital

The forty-bed Munroe Wing of the Regina General Hospital, established as a psychiatric ward in 1931, is administered directly by the provincial Department of Public Health. It has facilities for all types of intensive treatment for short-term patients. In

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(1) No legislation governs the duration of hospitalization in this psychiatric hospital but the length of treatment is short as compared with that of mental hospitals. In 1952, the average duration of stay was 21.7 days. Roughly 45 percent of the admissions were later transferred to mental institutions.

addition to caring for in-patients, the staff conducts three part-time travelling clinics at Yorkton, Swift Current and Assiniboia,(1) and one staff physician works part-time at the Regina Mental Health Clinic. Research is also carried on in collaboration with the mental hospitals.

In 1952, staff of the Munroe Wing included 5 psychiatrists, one of whom was concerned chiefly with administration, one with the travelling clinics and the remaining three with patients reporting to the psychiatric hospital.

The Crease Clinic of Psychological Medicine: Essondale

The Crease Clinic, a psychiatric hospital closely associated with the Provincial Mental Hospital at Essondale, British Columbia, was established under the Clinics of Psychological Medicine Act. This Act defined it as "a clinic for the examination, custody and treatment of the mentally ill", and limited the duration of hospitalization to four months. Admission is by voluntary application of the patient or by medical certification of two physicians on application of a relative or other interested responsible persons.(2) No loss of civil rights is involved, as evidenced by the provision of a polling booth for patients who are able to exercise their franchise on election days.

The Crease Clinic has accommodation for 302 patients. Facilities have already been described in discussing the Provincial Mental Hospital.(3) Two wards are now functioning as open wards and the use of seclusion rooms on other wards has become infrequent. Special patients from the Mental Hospital, Training School and Homes for the Aged may be admitted for surgery, as required.

Of the 1,193 patients discharged from the Crease Clinic in 1952-53, only 129 were committed to the mental institution for further treatment.

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(1) See section on Mental Health Clinics.

(2) In 1952-53, 45 percent of all admissions to the clinic (534 cases) were voluntary; this constitutes roughly one-quarter of all voluntary admissions in Canada for that year.

(3) See pages 75 and 77.

PSYCHIATRIC UNITS IN GENERAL HOSPITALS

As mentioned earlier, one of the more recent trends in Canada has been toward integrating mental health with other community services. This trend is readily apparent as one notes the increasing number of small psychiatric units developing in the general hospitals. These units are designed to provide facilities for observation pending diagnosis and for short-term therapy for cases that do not demand continued care. A patient is usually admitted on the same basis as to other general hospital departments; if, following an observation period and diagnosis the psychiatrist in charge of the unit considers that the patient may benefit by prolonged care, he is transferred to a mental hospital after fulfilling its admission requirements.

For the purpose of supplementing existing data on psychiatric services provided by general hospitals, early in 1952 the Department of National Health and Welfare distributed questionnaires to all general hospitals in Canada with a capacity of 100 or more beds.(1) Of the 166 hospitals circulated, 151 returned the questionnaire (90 percent returns) Of the 151, 73 (48 percent) reported some type of psychiatric service but only 10 had a complete active treatment program and a separate unit of 8 or more beds. The psychiatric units in the 10 hospitals varied in size from 8 to 43 beds, with a total allocation of 255.

All of the 10 hospitals with psychiatric units had facilities for psychotherapy and electro-convulsive shock treatment; nine gave sub-coma insulin and seven gave insulin coma therapy. The larger units provided various other types of therapy: nitrous oxide, ether and antabuse, group psychotherapy, narco-analysis and narco-synthesis, carbon dioxide treatment, glissando shock and hydrotherapy. Although all units were directed by psychiatrists, a complete psychiatric team including psychiatrist, psychiatric nurse, social worker, psychologist and occupational therapist was employed by only 4 out of the 10 hospitals.

In addition to the 10 hospitals which reported both an active treatment program and a separate unit of 8 or more beds, a second group of 16 hospitals had an organized clinical service but a more restricted active

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(1) Roberts, C.A. et al "Psychiatric Services in General Hospitals in Canada", The Canadian Medical Association Journal, 1953, vol, 68, pp. 578-582.

treatment program. Some hospitals in this group had a small psychiatric unit of less than 8 beds, but the majority had no definite bed allocation. Treatment facilities varied: of the 16 hospitals in this group, 13 gave psychotherapy, 11 electroconvulsive shock treatment, 10 had facilities for sub-coma insulin and 5 for insulin coma therapy. All of the 16 psychiatric departments were directed by psychiatrists; 8 employed psychologists, 9 social workers, 8 occupational therapists and 6 psychiatric nurses.

Apart from the 26 hospitals mentioned above, another 40 admitted patients for observation, diagnosis detention or limited treatment but had no organized clinical service in psychiatry. Some had a staff psychiatrist or a consultant in psychiatry and limited treatment was provided; others detained patients only until they could be transferred to some other institution.(1)

No follow-up survey of psychiatric facilities in the general hospitals has been made since 1952. This is an area where considerable expansion has occurred since that time, however. Data are available only for hospitals which have received assistance under the federal Hospital Construction Grant. Beds constructed with federal aid have already been discussed in the subsection "Mental Institution Accommodation".

Usually the psychiatric personnel on the general hospital staff are responsible for both in-patient and out-patient services. Except for a few types of therapy, the same facilities are also available to both in and out-patients. Accordingly, in order to avoid duplication, discussion of the in-patient services presently provided by the general hospitals is included in the section "Local Hospital and Clinic Services".

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(1) The remaining seven hospitals reported psychiatric outpatient services but no in-hospital accommodation.

INSTITUTIONAL CARE FOR SPECIAL GROUPS

In discussing trends in the historical development of mental health services in Canada, mention was made of the gradual segregation of various classes of patients. Groups for which special facilities have been developed by some provinces are the mentally defective, tuberculous mental patients, epileptics, alcoholics and seniles. Special services are described in the above order.

Services for the Mentally Defective

The American Association for Mental Deficiency has defined mental defectives as ". . . a group of persons, children or adults, who because of retardation in mental development, require special education adjustments and/or social or economic adjustments in order that they may reach the maximum of adjustability in any environment"(1). Thus, while the patients discussed in earlier sections of this report may have been self-sufficient, competent individuals prior to their illness, the mentally defective have never reached a stage of self-sufficiency. Some have more learning ability than others, however, and, if adequately cared for and trained, may become useful citizens; some may learn to care for themselves physically, while others are unable to learn even simple routines. Accordingly, the mentally defective may be roughly divided into three groups: those who are retarded but can be trained in opportunity classes within a school system(2), those whose ability is yet more limited but who may be trained by skilled personnel in a special training school and those who are unable to learn and require only custodial care. It is with the last two groups - the institutionalized mental defectives - that we are concerned in this section.

The extent of mental deficiency in Canada is not known(3). At the end of 1952, 14,714 names appeared on the books of the institutions. Provincial distribution of this total is shown in Table XII. However, the

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(1) This definition is also used by the Department of Justice in Canada.

(2) For a discussion of opportunity classes, see section "Mental Health Services in the Public Schools".

(3) Some authorities suggest that as many as 90 percent of all mental defectives are cared for in their own homes; however, there are no factual data either to support or refute this view

TABLE XII. MENTAL DEFECTIVES WITHOUT PSYCHOSIS IN CANADIAN INSTITUTIONS

Province	On books of mental institutions Dec. 31, 1952[1]	Rate of hospitalized patients per 100,000 general population	First admissions during 1952[2]	Rate of first admissions per 100 000 general population
Newfoundland	104	27.8	6	1.6
Prince Edward Island	33	32.0	4	3.9
Nova Scotia	452	69.2	25	3.8
New Brunswick	275	52.3	19	3.6
Quebec	5,054	121.1	632	15.1
Ontario	4,934	103.6	516	10.8
Manitoba	583	73.1	56	7.0
Saskatchewan	1,214	144.0	59	7.0
Alberta	665	68.6	96	9.9
British Columbia	1,400	116,9	187	15.6
Canada	14,714	102.1	1,600	11.1

(1) These figures represent 75 institutions.

(2) First admissions were reported for only 52 of the 75 institutions.

Source: Department of National Health and Welfare, Mental Health Division "Services for the Care and Training of Mentally Defective Persons in Canada". Ottawa, 1953, p.7.

variation in rate of hospitalized cases suggests only that some provinces had a greater shortage of accommodation than others in 1952 and totals cannot be interpreted in terms of incidence in the population, either in a province or for Canada as a whole. Moreover, in addition to the numbers recorded in Table XII, mental deficiency accompanied by psychosis or other complication would increase the totals considerably.

In 1948, all provinces with institutional facilities for mental defectives reported long waiting lists. It is in this area that the highest expenditures for mental health services have been made under the federal Hospital Construction Grant. From the inception of the grant to June 1954, 6,507 beds had been completed or were under construction in training schools and mental hospitals.

Newfoundland(1). Newfoundland has no special hospitals or training schools for the mentally retarded. Higher-grade defectives who have no families to care for them are the responsibility of the Department of Welfare which usually places them in foster homes. Lower-grade defectives may be admitted to the Hospital for Mental and Nervous Diseases in St. John's.

Prince Edward Island. The provincial mental health clinics are active in screening mentally retarded children within the school system. A child guidance clinic, which is being established as a part of the mental health clinic will also provide free services. Apart from the opportunity classes for the higher-grade defectives, however, no special training or custodial care is available. Lower-grade defectives may be cared for in the Provincial Infirmary. Children who are retarded as a result of cerebral palsy may attend special classes at the Red Cross Centre in Charlottetown.

Nova Scotia. Nova Scotia's Maritime Training School for Mentally Defective Persons, located at Truro, is operated jointly by the Departments of Welfare and Public Health. Only high-grade, trainable children are admitted(2). Non-trainable defectives of all ages are cared for by the county homes.

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(1) The Research Division is indebted to the Mental Health Division's bulletin "Sources for the Care and Training of Mentally Defective Persons in Canada" for many of the provincial data.

(2) Admission is limited to children within the IQ range of 50 to 70.

The provincial training school has accommodation for 215 children. All operating costs are paid by the province which recovers approximately 50 percent from the municipalities of residence of the patients. Some defectives receive training in opportunity classes provided through the school system.

New Brunswick. Apart from the all-purpose mental health clinics there are no child guidance clinics in New Brunswick and no hospitals or training schools for mental defectives. Mentally retarded children are screened by the staffs of the mental health clinics who assess the degree of retardation and make recommendations to parents and teachers. High-grade defectives in Moncton and Saint John may be admitted to the school system's opportunity classes. Some children are resident at the Provincial Hospital, Lancaster. In Saint John, there is a day school for retarded children where attendance is free. This is a joint project sponsored by the local mental health clinic and the local chapter of the Beta Sigma Phi Sorority.

Other accommodation includes unlicensed private homes which accept mentally retarded children as boarders, the Municipal homes and various children's shelters operated by the Children's Aid societies. Children's shelters admit only juveniles for whom no other community resources exist. The municipal homes accept both children and adults.

Quebec. Quebec has three institutions whose populations consist almost entirely of mental defectives: the Mont-Providence Hospital at Riviere-des-Prairies, the new Hopital Ste-Anne at Baie St. Paul and the Rehabilitation Society of Sherbrooke, Incorporated. Mental defectives are also admitted to the mental hospitals, as noted in the earlier discussion of hospitals for the mentally ill.

The Mont-Providence Hospital, a recently opened residential hospital-school, will ultimately accommodate 1,000 children. In March, 1953, the enrolment was 473 of which 193 were under 9 years of age and 274 in the 10 to 14 year range. The school is well equipped and staffed for teaching and rehabilitation work and has facilities for dentistry, radiology, pharmacy and optometry.

Of the other institutions, the Rehabilitation Society of Sherbrooke, Incorporated, which is affiliated with Laval University, also has a training program. Although this Society was established to care for

emotionally disturbed children of Sherbrooke and vicinity, its program was soon expanded to include mental defectives. According to the provincial health survey committee, over 300 retarded children were cared for in 1948. Usually children with IQ's of less than 60 are not admitted. In 1949, construction was begun in a 174 bed pavilion to house defectives. This has been completed and a program of psychological, educational and social welfare services is available to the children(1).

The last of the three institutions mentioned is the Hopital Ste-Anne at Baie St. Paul(2). Although the preponderance of residents are mental defectives without psychosis, other classes of patients are also admitted(3). All age groups are represented. No data are available concerning segregation of these patients or treatment facilities.

Mental defectives are admitted to all mental hospitals in Quebec. In December, 1953, 597 out of a total of 940 patients at Saint-Julien were classified as mental defectives without psychosis. The Hopital te-Elizabeth had 330 such patients out of a caseload of 684 and the Hopital Saint-Jean-de-Dieu, 1,446 defectives without psychosis out of a total of 5,924 registered.

Opportunity classes for retarded children and other services are discussed under the sections on schools and clinics.

Ontario. The province of Ontario operates three institutions for the care of mental defectives: the Ontario Hospital School at Orillia, the Ontario Hospital School

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(1) There is no record of medical services.

(2) No record is available of any training program; presumably the hospital admits all IQ ranges and provides chiefly custodial care.

(3) On March 31, 1953, the patient population was as follows:

Mental defectives without Psychosis	1,033
Psychotics	32
Epileptics with psychosis	13
Epileptics with mental deficiency	53
Other	10
Total	1,141

at Smiths Falls and the Ontario Hospital at Aurora. In addition, five private training schools for mentally deficient children are situated at Niagara-on-the-Lake, Orillia, Windsor, Oakville and Aurora.

The oldest of the provincially operated institutions is the Ontario Hospital School at Orillia. It has accommodation for 1,800 patients with provision for another 135 in boarding homes. Most of the residents are children

At Smiths Falls, one wing of the new Ontario Hospital School was opened in 1951. In December of that year, 403 patients were reported. Additional wings are being opened as facilities and staff become available, and when completed the school will accommodate 2,400 children in the 6 to 16 year age range. The Ontario Hospital at Aurora has also been constructed since the inception of the National Health Program. Admissions are limited to adult male defectives.

Other Ontario Hospitals admit the mentally defective but the numbers are small (10 percent) in relation to total caseload(1). In 1951, institutionalized mental defectives numbered roughly 4,934 or 28 percent of all inmates in the province's mental hospitals and training schools.

A number of voluntary agencies in Ontario have participated in providing training for retarded children who live at home. These organizations include the Parents' Council for Retarded Children, the Association for the Help of Retarded Children in London, and the Greater Windsor Parents' Association for Retarded Children. Schools operated by these groups receive $25 per child per month for 10 months each year on condition that the schools must be open for five half-days a week and that the funds be administered through the local group which must be affiliated with the Ontario Association for Retarded Children.

The Toronto School Board operates a number of opportunity classes. These are discussed elsewhere.

Manitoba. The Manitoba School for Mentally Defective Persons, located at Portage la Prairie, has accommodation for 763 patients (May, 1954). A 48 bed addition is being opened in July, 1954, and plans are under way

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(1) Evidence is lacking concerning any training facilities for mental defectives in hospitals designed primarily for the mentally ill.

for a new building of 180 beds to be completed in 1956 All grades of mental defectives were admitted until 1950 when patient population was comprised as follows: morons, 20.5 percent; imbeciles, 52 percent and idiots, 27 5 percent, thus indicating a preponderance of the less trainable groups(1). In 1950 overcrowding of the school had become so serious that admissions had to be limited to children so grossly defective that they "constituted an insufferable burden at home" and to higher-grade defectives who had become so anti-social that they were a threat to society. Although overcrowding was reduced to some extent when a new 282 bed unit was opened in 1952, it has continued to be a serious problem and waiting lists have not decreased significantly.

On the medical side, staff vacancies are being filled as personnel become available. The new unit which was opened in 1952 provided space for the installation of electroencephalographic equipment and it is anticipated that an EEG service will be in operation this year (1954). Electroshock therapy is also available.

The training program is entirely practical. Emphasis is placed on personal hygiene and on learning of simple crafts. Training in personal hygiene includes beauty salon routines - shampoos, fingerwaves and permanent waving. A full-time domestic science teacher instructs the higher-grade girls in household care and sewing; training in tailoring, shoe repair, woodwork and carpentry is available to boys. This program is expanding steadily as more staff and equipment become available and limited rehabilitation and welfare services are being extended to selected lower-grade defectives Staff deficiencies are being reduced but the shortage of skilled personnel continues to limit the work and is a serious problem.

In 1945, the Broadway Home for Girls was established to care for small numbers of girls discharged from the training school. Its purpose is to assist in the rehabilitation of girls who live in the Home but go out to work each day. When they "graduate" from the Home, they move to selected boarding houses or reside in the homes of their employers. General policy governing admission and care is in the hands of a committee chaired by the Director of Public Welfare for the province.

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(1) Evidence is lacking on the precise IQ levels used to distinguish these groups in Manitoba. Although this depends on the intelligence test used, the moron category usually includes persons with an IQ level of 50 to 70 with imbeciles and idiots ranging downward from the 50 IQ level in the order named.

Most of the opportunity classes operated by the school systems are in Winnipeg. Voluntary efforts have resulted in the organization of the Manitoba Association for Retarded Children. Its primary objective is to assist the Training School.

Saskatchewan. In Saskatchewan a separate training school for mental defectives was opened in temporary quarters at Weyburn in 1945. Permanent buildings, now under construction at Moose Jaw, will accommodate 1,100 patients. When these are completed in 1955, the Weyburn quarters will be vacated.

The Weyburn training school provides academic instruction for trainable children aged 7 to 17 years. A nursery school and kindergarten is operated for children of less ability. Classes in woodworking and homemaking are available, occupational and recreational therapy include crafts, choir and glee clubs, music appreciation groups, rhythm bands and rhythm games, folk and social dancing. Social workers assist in placing "graduate" girls in domestic employment and boys in farm work.

Other services for retarded children include a small private day school in Regina and opportunity classes operated by the school systems in Regina and Saskatoon.

Alberta. Alberta's Provincial Training School is located at Red Deer. Although all grades of mental defectives are admitted, emphasis is placed on both academic and vocational training for those who are able to learn. A high discharge and placement rate is reported.

Accommodation and services have both been extended through addition of a new eight-room school. Present bed capacity is around 660. Construction has begun on a new institution for adult defectives who are presently receiving custodial care in the hospitals for the mentally ill and in the present training school.

British Columbia. British Columbia has one provincially operated training school, the Woodlands School at New Westminster. Under the School for Mental Defectives Act, passed in 1953, patients may be admitted directly without passing through the admission centre of the mental hospital at Essondale.

In recent years the Woodlands School has developed considerably. In 1950, the first of a series of four specially designed buildings was opened; the

other three were opened in 1952, raising total capacity to 1,182 patients. New admissions decreased a long waiting list of preschool age children and enabled the Essondale hospital to transfer children to Woodlands. The school admits retarded patients of all IQ levels; age ranges from infancy to adulthood.

The Woodlands School has a full-time medical service including modern facilities for radiological and laboratory tests. Organized divisions concerned with training include the academic school department and separate departments of occupational therapy, recreational therapy, nursing, psychology and social work. The social service department is directed by the supervisor of psychiatric social work at Essondale. In 1952, rehabilitation work was begun with five pupils on an experimental basis.

In addition to the provincial training school, a small private boarding school -- the St. Christopher's School -- is operated in North Vancouver. The Vancouver Provincial Child Guidance Clinic provides an examination service for patients being admitted. The school is inspected by the provincial Department of Welfare.

Special classes for higher-grade mentally defective children are sponsored by the City of Vancouver school board; in other provincial school systems special attention is given to retarded children. In several centres parents of retarded children, assisted by local schools, churches and the Public Health Department, have organized opportunity classes. A branch of the Association for the Advancement of Retarded Children has been formed in Vancouver.

Services for Tuberculous Mental Patients

Because the onset of tuberculosis is characteristically slow and insidious and because it is extremely contagious in nature, the control of tuberculosis has become a vitally important part of the service for institutionalized mental patients.

Statistics on deaths from tuberculosis among the mentally ill are available only for recent years.(1) In 1951, 273 patients died from this cause in mental institutions; the following year, the number had been

(1) Data are available for some but not for all provinces; for example, in Quebec the record of deaths goes back to 1931.

reduced to 210. As a result of improved treatment, the percentage of deaths due to tuberculosis declined from 9.2 percent in 1951 to 7.1 in 1952.(1)

Segregation of tuberculous mental patients has increased steadily in recent years. In 1950, mental institutions reporting to the Dominion Bureau of Statistics had set aside a total of 1,964 beds for tuberculosis patients; by 1952, the number had risen to 2,142. All provinces maintain separate accommodation for this class of patient. Distribution by province has been reported as follows:

	1950	1952
Newfoundland	12	12
Prince Edward Island	10	10
Nova Scotia	29	70
New Brunswick	115	69
Quebec	556	770
Ontario	641	628
Manitoba	133	107
Saskatchewan	124	114
Alberta	135	144
British Columbia	209	218
Canada	1,964	2,142

In addition to the increase in beds, tuberculosis case finding and diagnostic services have improved substantially both for new admissions, in-patients and staff. Diagnostic chest x-rays of suspects are used in all institutions and mass x-ray surveys, covering both staff and patients, are common in all provinces. The improved services are yielding good results in control and reduction of the disease.

Newfoundland. Prior to 1953, a twelve bed isolation ward for tuberculous mental patients was maintained in the Hospital for Mental and Nervous Diseases. In 1953, a 36 bed isolation unit with facilities for treating active tuberculosis cases was established under supervision of the Superintendent of St. John's Sanatorium, and quiescent cases occurring among custodial care patients were also segregated. A similar wing of 29 beds in the female wing of the hospital has been designated for tuberculosis cases.

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(1) D.B.S. Tuberculosis Institutions, 1951 and 1952.

Prince Edward Island. The Falconwood Hospital maintains a ten bed ward for tuberculosis patients. Close cooperation is maintained with the Division of Tuberculosis Control through the Medical Director of Clinics who acts as consultant in diagnostic and treatment procedures. All new admissions are x-rayed at the Provincial Sanatorium; staff members are x-rayed on appointment and subsequently as indicated. Complete surveys are carried out yearly by the mobile x-ray unit.

Nova Scotia. Between 1950 and 1952, the number of beds set aside for tuberculous mental patients increased from 29 to 70.

New Brunswick. An isolation ward is maintained in the provincial hospital at Lancaster. A similar unit will be established in the new hospital at Campbellton which opened recently.

Quebec. The three larger hospitals - the Saint-Jean-de-Dieu, the Saint-Michel-Archange and the Verdun Protestant all provide self-contained tuberculosis treatment units; all have organized services for the control of tuberculosis. Services are under the direction of a physician who is responsible for routine x-ray and B.C.G. vaccination. The Verdun Protestant Hospital operates a diagnostic x-ray program for the whole institution.

Ontario. The Ontario Hospital at Woodstock has a Chest Diseases Division which provides accommodation for all tuberculous mental patients in the province. The number of cases admitted has declined from 179 in 1938 to 88 in 1952.

Manitoba. Special wards are maintained in both the Selkirk and Brandon institutions. Routine x-rays are made regularly of all hospital residents.

Saskatchewan. A special unit has been established in the Saskatchewan Mental Hospital at Weyburn to care for patients with tuberculosis. This unit admits and cares for tuberculous psychotics and defectives from the other Saskatchewan institutions.

Alberta. Until 1952, tuberculous mental patients were segregated on a separate ward in the mental institutions at Ponoka. At that time, however, construction was begun on a separate wing at the provincial hospital at Edmonton. This will provide isolation beds for all tuberculous mental cases in the province.

British Columbia. Up to the present time, tuberculous patients have been cared for in special wards in the mental institutions. A new tuberculosis unit is now under construction at the Provincial Mental Hospital at Essondale. When opened in 1955, this will accommodate 230 patients.

Services for Epileptics

Epileptics comprise only a small percentage of the mental hospital population in Canada. According to the Dominion Bureau of Statistics, only 1,938 of the 62,704 patients reported were classified in this category(1). This is just over three percent. Only two provinces, Ontario and Saskatchewan, make any legal provision for admitting epileptics to the mental institutions(2); two provinces, Nova Scotia and Prince Edward Island, specifically release the hospital superintendent from any legal obligation to admit them; the other six provinces make no mention of them whatever in their statutes

Nevertheless, epileptics without psychosis are sprinkled through the hospital populations of all provinces and in most instances receive treatment in due course along with the mentally ill. Ontario and Quebec have separate institutions for epileptics. Ontario has reserved one of the two divisions of the hospital at Woodstock for serious cases of epilepsy; both psychotic and non-psychotic epileptics are admitted and on December 31, 1951, there were 162 psychotic epileptics, 88 non-psychotic epileptics and 363 mentally defective epileptics in residence. Psychiatric and other medical services are available in this hospital and a substantial occupational therapy program is carried on. Leucotomies and other special treatments are given in cooperation with the local general hospitals

In Quebec, the Foyer Dieppe at St. Hilaire (Montreal), the Hotel-Dieu-du-Sacre-Coeur de Jesus in Quebec City and the Etablissement Notre-Dame at Saint-Charles-sur-Richelieu are exclusive to epileptic patients. Few epileptics without other complications are admitted to the other mental institutions(3).

(1) D B.S Mental Institutions, 1952, p. 17, Table 12.

(2) See section "Legislation Governing Hospitalization of the Mentally Ill".

(3) In 1953, the Hopital Ste-Elizabeth reported 12 cases of simple epilepsy and the Saint-Jean-de-Dieu, 20 cases. No data are available for the Hopital Saint-Michel-Archange.

Although the Foyer Dieppe is often reported as a mental institution, it is really a hospital specialized to treat male epileptics, aged 15 to 55, without psychosis or other complications. Usually care and treatment are free to the patient. Skilled medical and nursing care is provided and a complete rehabilitation program is carried on. In 1953, 70 patients were reported and a long waiting list testified to the demand for beds.

The Etablissement Notre-Dame, owned and operated by a Roman Catholic religious order, cared for 140 patients in 1953.

The Hotel-Dieu-du-Sacre-Coeur de Jesus is closely affiliated with Laval University. While it sets aside 190 beds for epileptics, it also admits a variety of other patients including tuberculous and orthopaedic cases. The hospital has several departments: medical, surgical, ophthalmic, pharmaceutical and electroencephalographic as well as an independent laboratory. All departments are well equipped. In addition to in-patient services, the hospital also operates an out-patient clinic for neuro-psychiatric patients.

Apart from Ontario and Quebec, no other province has separate institutions for epileptics, but all make some provision for cases complicated by psychosis or mental deficiency. In Newfoundland, epileptics are admitted to the Hospital for Mental and Nervous Diseases only when they are psychotic and "unmanageable amongst the general population"; simple cases attend the out-patient clinic for routine re-assessment and medication A similar approach is used in Prince Edward Island where disturbed cases are cared for at the Falconwood Hospital and a few simple cases at the Provincial Infirmary. Nova Scotia, too, states that "whether or not epileptics get into the mental hospital depends on the presence or absence of an associated psychosis". In New Brunswick only 76 epileptics were admitted to the mental hospital during the three-year period ending December 31, 1953

In the Western provinces the general policy also appears to be to admit only epileptics with other complications(1). Manitoba reports that in 1952, electroencephalograms were taken of 83 epileptics in the Hospital for Mental Diseases at Brandon. Alberta recorded the presence of 9 epileptics at the Provincial

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(1) There is no record of such policy; it is merely interpreted from the statistics available coupled with provincial comments.

Hospital, Ponoka, in 1951, and in the same year British Columbia reported 4 cases of simple epilepsy resident at Essondale. The Crease Clinic also treated 18 cases. In addition to these figures, however, there were many cases of epilepsy associated with mental deficiency or psychosis. These are included in the discussions of services for the mentally ill and for the defective.

Services for Alcoholics

Most mental hospitals in Canada provide some special care for both psychotic and non-psychotic alcoholics(1). In addition, many general hospitals with psychiatric services give short-term treatment to both in and out-patients, and all psychiatric hospitals treat this class of patient. In recent years, a number of Alcoholism Foundations have been established for research purposes and to provide special services for treatment and rehabilitation.

Newfoundland, Prince Edward Island and Nova Scotia care for some alcoholics in the provincial institutions. Overcrowding in the hospitals has limited this service in Newfoundland to acute cases, however.(2) In Prince Edward Island only those who show symptoms of disturbed behavior are admitted to the Falconwood Hospital. The Nova Scotia Hospital cares only for alcoholic patients with psychosis; patients with acute alcoholism are sometimes admitted to the general hospitals but according to information received from the province, as a rule these hospitals try to avoid taking such patients. The Alcoholics Anonymous Society works in close cooperation with the Nova Scotia Hospital.

In New Brunswick, alcoholics are treated by the mental hospital at Lancaster and the provincial mental health clinics. In June, 1954, the general hospitals at Moncton and Saint John also began to accept alcoholics as in-patients. Close liaison is maintained with the

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(1) D.B.S. Mental Institutions, 1952, p. 26. Out of a total of 11,696 first admissions to mental institutions in 1952, 324 were psychotic alcoholics and 450 were alcoholics without psychosis.

(2) Newfoundland (May, 1954) states: "Again due to the extreme shortage of beds it is impossible to admit the numbers of routine alcoholics that were previously referred to this service. In the past they received a two to three weeks period on the admission ward and were referred back to the local Alcoholics Anonymous group."

Alcoholics Anonymous, both in regard to treatment and to educational services. The Director of the province's Alcohol Education Program sums up progress in this field(1):

> ... At all times, a close liaison is maintained between this office and the A.A. groups. Problem drinkers are referred to A.A. when hospitalization does not appear to be indicated. In January of 1954, a move forward was made by the New Brunswick Medical Society in a resolution concerning treatment of the acutely ill alcoholic. They urged that general hospitals accept alcoholics for appropriate treatment of the acutely ill phase of the disorder. This resolution is already easing the burden of the mental hospital in Saint John and is preparing the way for the role of the mental hospital as an institution for long-term treatment. It is expected that the new mental hospital at Campbellton will look favorably on a group therapy plan for alcoholics, designed for long-term recovery....

The Alcohol Education program, established in 1952 under direction of the Mental Health Division of the Department of Health, was transferred to the Welfare branch of the provincial department in June, 1954. It will now be administered by New Brunswick's first and newly appointed Chief Welfare Officer.

In Quebec, the larger mental institutions admit some alcoholics. The Bordeaux Hospital, operated by the provincial government cares for alcoholics accused of offences against the law. The Allen Memorial Institute operates an Alcohol Centre where psychotherapy and medical treatment are provided on an out-patient basis. Private institutions including the Sanatorium Prevost, the Retrait Saint-Benoit and the Sanatorium Mastai offer in-patient treatment for alcoholism. In 1950, the Montreal Council of Social Agencies organized a Committee on Alcoholism to study the problem and to assess treatment facilities in the metropolitan area. Research is now in progress.

The Alcoholism Research Foundation in Toronto, established in 1949, provides treatment services for out-patients as well as emergency and convalescent care

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(1) Cited from a direct communication from the New Brunswick health department, May, 1954.

for both men and women. It has also launched an extensive research program in collaboration with several provincial universities. Grants from the Ontario Legislature, the Liquor Control Board of Ontario and the federal government have enabled the Foundation to maintain a substantial service. Alcoholics in acute toxic phases are admitted to the Toronto General Hospital; following 2 or 3 days treatment there, they may be transferred to the Foundation's 21 bed convalescent hospital for another 14 days of medical treatment and psychotherapy. After this maximum of hospitalization the patient is referred to the Foundation's out-patient clinic or to Alcoholics Anonymous. The out-patient clinic provides diagnostic, consultative and treatment facilities for both patients and their families. The cost to the patient is based on his ability to pay.

The research program of the Alcoholism Research Foundation is financed in part under the National Health Program. To date (1954), it has included a survey of the incidence of alcoholism in Ontario and studies on the effect of alcoholism on traffic accidents. In 1954, a Director of Education was appointed to develop a comprehensive program of public education.

The Ontario Department of Reform Institutions is also concerned with the problem of alcoholism. It operates a clinic for the treatment of alcoholics at the Ontario Reformatory in Mimico. This clinic which accommodates 30 patients at a given time, provides extensive treatment for short-term prisoners over the age of 21 years. In addition to the above, the Bell Clinic, privately sponsored, has both in-patient and out-patient facilities for diagnosis and therapy.

In the province of Manitoba, the Winnipeg Psychopathic Hospital is the major centre for treatment of alcoholics without psychosis. In 1953, over 12.5 percent of the hospital's beds were occupied by such patients. Recently the general hospitals have adopted a more lenient admission policy for the acute alcoholic. Frequently patients are also helped by Alcoholic's Anonymous, whose members do some bedside sitting to relieve the hospitals of the burden of nursing disturbed patients. In 1952, a Committee on Alcoholism for Manitoba was established, this has received support from the provincial government. At present (1954) it is studying plans for increasing in-patient services in three large general hospitals.

Saskatchewan admits alcoholics to its mental hospitals. Both in and out-patient treatment is also provided by the Munroe Wing of the Regina General Hospital. Recently a provincial Bureau of Alcoholic Studies was established with a broadly representative advisory committee which includes the provincial Director of Psychiatric Services.

An Alcoholism Foundation has also been established in Alberta but up to 1953 it did not provide any treatment service(1). Persons suffering from acute alcoholism are admitted to the mental institutions.

An Alcoholism Clinic was opened at the British Columbia Provincial Mental Hospital at Essondale in 1952. Psychotic alcoholics are admitted to the institution. Short-term therapy may be obtained on a voluntary basis for alcoholics without psychosis. Voluntary patients may not leave before 30 days but may and do remain longer, if further therapy is deemed desirable. British Columbia, too, has recently established an Alcoholism Foundation.

The major voluntary organization in this field is the Alcoholics Anonymous Association which has groups across Canada. Religious groups may also be concerned with rehabilitating alcoholics under a pledge program. Among the religious groups are the "Les Lacordaire" and the "Jeanne d'Arc" in the province of Quebec.

Services for Seniles

As the lifespan of Canadians increases, a higher number of senile patients may be anticipated. This trend has already become evident in recent years for senility and arteriosclerosis ranks second among the most frequent causes of admission to mental institutions, surpassed only by schizophrenia(2). So far, no solution has been found to this growing problem although two provinces have provided separate accommodation for seniles and others are planning special programs both in the interests of economy and of the patients themselves.

In Newfoundland, overcrowding in the one provincial mental hospital has precluded the admission of senile patients except in extreme cases where they are unmanageable at home or dangerous to those around them. Female senile patients, admitted to the hospital, are cared for on a special ward under supervision of a

(1) These are the most recent data on hand.

(2) D.B.S. Mental Hospitals, various years.

graduate nurse. Relatively healthy male seniles are sent to the "chronic" maintenance psychiatric unit at the General Hospital, while the physically ill are cared for on the male or female hospital wards.

In Prince Edward Island, various elderly people, some of whom may evidence some degree of senility, are admitted to Beach Grove, a welfare institution. A number of cases are cared for in the Provincial Infirmary as long as their behavior appears relatively normal. Those who show symptoms of disturbance are admitted to the Falconwood Hospital.

The majority of senile patients with psychosis in Nova Scotia are maintained in the municipal hospitals where they are sent following diagnosis; those without psychosis are sent on to the county homes. This is not an invariable rule, however, since the borderline between patients with and without psychosis is often indistinguishable in this aged group.

There is no special provision for seniles in New Brunswick. They may be admitted to the mental hospital and they may also be found in the municipal homes and in unlicensed homes for the aged.

No data are available concerning the care of seniles in Quebec. Some appear on the records of the mental institutions but it is not known whether these constitute any substantial percentage of the senile population. Some are cared for in private nursing homes or hospitals sponsored by lay and religious groups. This is true of Ontario, Manitoba and Saskatchewan as well. Manitoba reports that seniles are cared for in mental hospitals "when found unsuitable for nursing homes and homes for the aged, which are in good supply in the Winnipeg area".

Alberta and British Columbia are the only two provinces which, to date, have made some special provision for aged mental patients. In Alberta, the Rosehaven Home for the Aged, was established specifically for seniles. Rosehaven, under the direction of a registered nurse, accommodated 302 patients in 1953.

The British Columbia program is more comprehensive. Separate quarters for seniles were first provided in conjunction with the provincial mental hospital at Essondale. In 1936, however, the growing number of aged patients prompted the province to convert a part of an industrial school at Port Coquitlam to the use of aged

patients. Subsequent construction in 1946, 1947 and 1952 increased the original building by 300 beds. Demand for accommodation continued to exceed supply and in 1948 a second independent 200 bed unit was opened at Vernon. Patients sent from Essondale were carefully selected ambulant cases, both male and female. In 1950 a third home for seniles was opened at Terrace. This was limited to male patients.

In summary, the problem of care for seniles is far from solved. So far, some are admitted to mental institutions while some are cared for in homes operated chiefly by welfare departments or welfare agencies. Only in British Columbia and Alberta have separate quarters been specially designed for the aged patient.

LOCAL HOSPITAL AND CLINIC SERVICES

More and more, mental health clinics are being accepted as an essential component of community health services. Depending on their purpose, clinics are operated by various agencies including provincial health departments, municipalities or health units, mental or psychiatric hospitals, children's hospitals and child health centres, tuberculosis sanitaria, general hospitals, school boards or voluntary organizations. Some are full-time, others part-time and some are held at regular or irregular intervals; some are stationary clinics while others are held by travelling teams that move from place to place on regular schedule or on request.

The "average" clinic team consists of a psychiatrist, a psychologist and a social worker. Mental Health Clinics in the larger hospitals, however, are usually better staffed and equipped to provide treatment. Frequently the out-patient has access to the same facilities as the in-patient of the psychiatric ward or unit. Smaller clinics and travelling teams may provide only a screening service for referred cases, and may give no treatment whatever but merely advise the source of referral concerning the patient's mental status and concerning future therapy and places where such therapy may be obtained.

Clinic services have expanded rapidly in Canada since the inception of the National Health Program in 1948. Although no specific mention is made of the Mental Health Grant or the Professional Training Grant, there are few clinics in any province that have not received substantial financial assistance toward expanding their work, either through help in training or employing personnel or both. Many clinics are financed entirely through federal grants.

Newfoundland

Although Newfoundland has no psychiatric units in general hospitals, patients are admitted for psychiatric treatment to three general hospitals in St. John's - the St. John's General Hospital, the St. Clare's Mercy Hospital and the Salvation Army Grace Hospital. Services are limited, however. The St. John's General Hospital makes consultation available to all in-patients but treatment is restricted to private patients.

The Hospital for Mental and Nervous Diseases operates a full-time out-patient department with facilities for both diagnosis and treatment, including occupational and recreational therapy and social services. A day hospital containing three units of eight beds each is used for out-patients requiring insulin coma or electroconvulsive shock therapy. As many as 35 patients receive treatments daily and return to boarding houses in St. John's in the evenings. The out-patient department also makes available consultative services to the Departments of Welfare, Education and Justice as well as to general practitioners throughout the province.(1)

Prince Edward Island

In Prince Edward Island there are no psychiatric units in general hospitals, but the Falconwood Hospital maintains an out-patient service for electroshock therapy.

In 1952, a part-time mental health clinic was opened at the Provincial Health Centre in Charlottetown to provide consultative services to both adults and children. It is staffed by a psychologist and a social worker from the provincial mental hospital. The clinic is operated partly as a stationary unit in Charlottetown and partly as a travelling clinic which visits various general hospitals throughout the province. Operating costs are met by federal health grant funds.

Nova Scotia

The Director of the provincial Division of Neuropsychiatry in Nova Scotia also heads the Department of Neurology, Neurosurgery and Psychiatry of the Victoria General Hospital in Halifax. This hospital has no separate psychiatric unit but private patients are admitted for treatment and, although the Halifax Infirmary also admits psychiatric cases, the Victoria General carries the major caseload. In addition to treatment, staff of the Department of Neurology, Neurosurgery and Psychiatry provide consultation to other departments of the hospital. Staff consists of 5 part-time psychiatrists, a social worker and 2 psychologists who co-operate closely with the resident medical staff and medical internes.

(1) See map, page 58 , for mental health clinics in the Atlantic Provinces.

The out-patient department of the Victoria General Hospital has a comprehensive program. Consultation is available to courts and social service agencies, consultation and treatment is provided on the request of medical practitioners, out-patient therapy is given as needed and follow-up work is done with former in-patients. In 1952, the in-patient service cared for 37 patients and the out-patient department for 545 patients; consultations requested by private practitioners numbered 316.(1) Facilities are available for psychotherapy, shock therapy and other treatment for both in and out-patients.

Another clinic in Halifax has in the past been supported by funds from the four Atlantic provinces. Until recently, this was called the Dalhousie Child Guidance Clinic but on April 1, 1954, its name was officially changed to the Halifax Mental Health Clinic for Children. Provision was made for enlargement; when operating at capacity it will employ two part-time psychiatrists, a psychologist, 2 social workers and secretarial help. On the given date, Nova Scotia assumed full responsibility for the clinic which is now financed jointly through funds from the city of Halifax and the federal Mental Health Grant.

To extend services to points remote from Halifax, the province operates a field psychiatric clinic with headquarters in Sydney. This is staffed by a full-time psychiatrist and a psychiatric nurse. Services include consultation, education and child guidance, mental testing, consultation to local courts and practising physicians and a limited treatment service.(2)

A stationary community clinic has been established at Digby. This is designed primarily for research purposes,(3) but provides consultation and psychotherapy on request.

New Brunswick

In New Brunswick, the Department of Health and Social Services operates three community mental health clinics at Saint John, Fredericton and Moncton.

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(1) Nova Scotia: Annual Report, 1952, p. 226.

(2) Both the clinic centered at Sydney and the Digby Clinic are financed through federal grants. This also applies to all clinics in New Brunswick.

(3) The Digby Clinic is supervised by Dr. A.H. Leighton of Cornell University, Ithaca, N.Y.

Prior to 1952, the Saint John Mental Health Clinic had been operated on a part-time basis. In 1952, however, the full-time services of a psychiatrist, psychologist and psychiatric social worker were obtained. At the present time (1954), services include consultation, assistance to schools and courts, educational work and out-patient treatment of selected cases. Well over half of the staff time is devoted to child guidance.

The Fredericton Mental Health Clinic was opened in 1952 on a part-time basis but began full-time operations the following year. It is also staffed by a clinic team consisting of a psychiatrist, a psychologist and a psychiatric social worker. Services extended are similar to those in Saint John.

The Moncton Mental Health Clinic was also opened on a part-time basis, but, like the Saint John clinic expanded its services in 1952 when full-time staff was secured. In addition to the psychiatric team it also employs a part-time speech therapist. Apart from speech therapy, its program is similar to those of the other clinics. Close liaison is maintained with the Moncton General Hospital where an electroshock unit was installed in 1952. At the present time the Moncton General Hospital has only an out-patient department but plans are under way to set aside a psychiatric unit.

For areas not served by the three clinics, a screening service is being developed. This consists of a clinical team of a psychologist and a social worker who periodically visit any centre where a group of cases has been assembled. In 1952-53 when this service began, it was provided for the Woodstock area.

Quebec

Like its mental hospitals, most of Quebec's mental health clinics are closely affiliated with the three major universities - Montreal, McGill and Laval. To clarify the complex picture of community clinics, they have been arranged in two major groups in Appendix II.(1) Group I lists the clinics serving the Montreal area and western Quebec, while Group II records all clinics operating in the Quebec City area and the eastern part of the province. Subdivisions within each major group indicate A. hospital clinics directed by universities, B. hospital clinics not directed by universities, and C. non-hospital clinics affiliated with

(1) See pages 199 and 200.

universities. The type of hospital or organization sponsoring the clinic is indicated by a bracketed code letter following the name.(1) The following discussion follows the arrangement of Appendix II.(2)

I. Montreal Area and Western Quebec

A1. Hospital Clinics Directed by the University of Montreal

The first three hospitals listed in Appendix II - the Hotel-Dieu-de-Montreal, the Hopital Notre-Dame and the Hopital de la Misericorde - are teaching hospitals for the University of Montreal. For this reason they are more closely linked with the university than others mentioned in this part of the list. Both the Hotel-Dieu-de-Montreal and the Hopital Notre-Dame have psychiatric wards for in-patients(3) although these wards have not been formally designated as psychiatric units. All three hospitals have neuro-psychiatric clinics for out-patients.

The Hotel-Dieu-de-Montreal clinic, directed by a psychiatrist, operates a day centre for treating patients who spend the day at the hospital but return home at night. Services including insulin and electro-shock therapy, electroencephalography, psychotherapy, psychometric testing and social welfare care are available to both in and out-patients. The Hopital Notre-Dame provides similar services. The Hopital de la Misericorde is for maternity cases only. Clinical services, consisting mainly of psychometric testing and social welfare care, are available only for in-patients and ex-patients of the hospital.

St. Mary's Hospital, also in Montreal, is a general hospital for the English-speaking Catholic population. In 1944 a child guidance clinic was established to provide psychiatric and psychological services (including play therapy) for children. Under the National Health Program, out-patient services were expanded to include adults and the clinic became a regular neuropsychiatric clinic. It takes cases

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(1) To interpret the code letters, see the key below the list.

(2) See also the map opposite page 62.

(3) The Hotel-Dieu de Montreal has a 28 bed psychiatric ward and the Hopital Notre-Dame has 23 beds.

referred by the Allen Memorial Institute and the Catholic Welfare Bureau as well as a wide variety of other out-patients. Services available include psychotherapy, psychometrics and vocational guidance.

The Hopital Ste-Justine is maintained exclusively for children. In addition to out-patient services, it has a psychiatric ward of 34 beds. Both in and out-patient services are directed by a psychiatrist.

In addition to the above, a neuropsychiatric clinic was established late in 1953 at the Maisonneuve Hospital which serves French-speaking residents of Montreal. Services provided by the Sanatorium Prevost have been described under "Psychiatric Hospitals". Ten beds in this hospital are available for out-patient use and clinics are held regularly for casual patients. Out-patients from poor home environments may use the clinic's recreation facilities during the day; some indigent out-patients are hospitalized. In addition to accepting casual patients who report directly, the Sanatorium clinic also provides services for ex-patients of the Hopital Saint-Jean-de-Dieu. It also has a chapter of Alcoholics Anonymous.

The neuropsychiatric clinic of the Verdun General Hospital is of recent origin. It was opened in November, 1953, under the direction of the University of Montreal to serve the population of Verdun on the Island of Montreal. The remaining two hospital clinics in or near Montreal are located in the Hopital du Sacre-Coeur and the Sanatorium Saint-Joseph-de-Rosemont. Both institutions are tuberculosis hospitals and their clinics serve only in-patients.

Saint-Vincent-de-Paul, a general hospital, is situated near Sherbrooke, about 120 miles southeast of Montreal and roughly midway between it and Quebec City. This hospital has a 15 bed psychiatric ward. Its clinic serves both in and out-patients, providing shock therapy to patients and social welfare services to patients and their families.

A2. Hospital Clinics Directed by McGill University

Under direction of McGill University are the out-patient services provided by six hospitals: the Royal Victoria Hospital, the Montreal General Hospital, the Children's Memorial Hospital, the Jewish General Hospital, the Royal Edward Laurentian Hospital and the Verdun Protestant Hospital. Especially close liaison is maintained with the first three mentioned which are the university's major teaching hospitals.

The Out-patient Department of the Royal Victoria Hospital has a full-time mental health clinic for out-patients. However, as noted earlier, the Allen Memorial Institute, which is only a couple of city blocks removed, provides day treatment and other psychiatric services for Royal Victoria patients and the same psychiatric personnel serve both institutions.

The Montreal General Hospital is divided into two sections separately located in the downtown area: the Western Division, frequently known as the "Western Hospital", and the Central Division. Each provides out-patient services. The Central Division maintains a 14 bed psychiatric unit for female in-patients, with complete facilities for psychotherapy and shock treatment in addition to its regular out-patient services. Some out-patients also receive short-term therapy in this unit. The Western Division has no residential facilities for psychiatric patients but operates a day hospital with facilities for shock treatment, psychotherapy and occupational therapy.

The Department of Child Psychiatry at the Children's Memorial Hospital provides a complete range of services including group therapy, play therapy, speech therapy and remedial education. It was one of the first centres in Canada to employ a speech therapist. Services have been greatly expanded during the past few years, both with aid of federal grants and independently and it is planned to begin construction on an entirely new hospital in 1955. At the present time, it has an active and comprehensive research program, conducts an auxiliary out-patient clinic in a downtown area and serves as a teaching centre for the McGill Schools of Social Work, Medicine, Nursing and Psychology at both graduate and undergraduate levels.

At the Jewish General Hospital, the Psychiatric Department provides consultation and treatment, including psychotherapy, psychometrics and group therapy to public ward patients. The out-patient clinic gives electroshock as well as other forms of short-term therapy. A child guidance clinic is held weekly.

The services afforded by the Verdun Protestant Hospital have already been described.(1) In addition to caring for its own patients it maintains a travelling clinic which makes periodic visits to Sherbrooke.

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(1) See page 64.

The only tuberculosis hospital associated with McGill University is the Royal Edward Laurentian Hospital. Its psychiatric services provide consultation and therapy for both in and out-patients, carries on a research program and gives training to public health nurses. It also serves in a consultant capacity to the tuberculosis hospital located at Ste-Agathe-sur-Monts.

B. Hospital Clinics Not Directed by Universities

Apart from the out-patient services provided by hospitals affiliated with the two universities, one other hospital in Montreal operates a clinic which serves the French-speaking population. This is the Ste-Jeanne-D'Arc Hospital. Although it has no formal psychiatric unit, some beds are set aside for psychiatric in-patients.(1) Out-patient services include shock treatment and psychotherapy.

C. Non-Hospital Clinics

In addition to the out-patient services available in the various hospital clinics discussed above, two other programs provide mental health services in the Montreal area. These services tend more toward psychotherapy and guidance of less disturbed cases since both lack facilities for medical therapies such as shock treatment.

Centre d'Orientation. The Centre d'Orientation (Guidance Centre) is an adjunct to the Institute of Psychology of the University of Montreal. It operates as a teaching and research institute, providing a part of the training for students specializing in clinical psychology. It serves in a consultant capacity to various welfare agencies throughout the city and maintains a residential service for boys, aged 7 to 13, who are trainable but who have scholastic, personality or family problems. The period of residence is 1 to 3 years, with subsequent follow-up work when they return home. In 1950, the out-patient service included diagnostic work with children and counselling for parents of children with problems, as well as a re-education service (involving play therapy) for the young patients. Consultation is also available to adults.

(1) The number of beds is not known.

The Mental Hygiene Institute. The Mental Hygiene Institute is affiliated with but not directed by McGill University. It maintains close liaison, too, with the Canadian Mental Health Association, especially on planning its educational work.

The Institute has a complete psychiatric and psychological service for children. Although no age limit is set for its cases, most of them are young children - many of preschool age. Referrals are made by the Montreal Children's Aid Society, the Protestant Foster Home, the Catholic Welfare Bureau, Juvenile Courts, hospitals, schools, physicians both public and private, Day Nurseries, the Family Welfare Association and other sources. In 1950, an extensive waiting list was reported but staff has been substantially increased since that date.

The scope of the services rendered by the Institute is wide: group therapy for children with problems and for their mothers; psychiatric examination of children up for adoption; investigations of school failures; school mental health services for children in the Westmount area; psychiatric consultation at "Well Baby Clinics"; group therapy to community organizations in the University Settlement, Girls' Counselling Centre and the Verdun Y.W.C.A., and parent education anywhere in the city, on request. A mental health clinic was also established for The Children's Service Centre in 1953, and a Marriage Counselling Service was initiated around the same time.

In addition to its work in the city proper, the Institute sends a travelling clinic team to visit the training schools for delinquent boys at Shawbridge and for girls at St. Bruno.

D. Services Provided by the City of Montreal

Under direction of a psychiatrist, the Mental Health Section of the Division of Child Hygiene provides limited psychiatric and psychological services to children referred because of suspected mental retardation, emotional or behaviour problems. Referrals may be made either by the Catholic or the Protestant School Board, social agencies, hospitals, private physicians or families. In 1951, 557 cases were reported. Services available include counselling and placement in institutions or auxiliary classes.

II. Clinics Serving the Quebec City Area and Eastern Quebec

A. Hospital Clinics Directed by Laval University

Hospital out-patient departments under the general direction of Laval University include the Hotel-Dieu, the Hopital St-Sacrement, the Hopital St Francois d'Assise, the Hopital l'Enfant-Jesus and the Jeffery Hale Hospital in Quebec City as well as the Hotel-Dieu de Chicoutimi and the Hotel-Dieu de Levis located as the names indicate. Of these, the Hotel-Dieu, the Hopital St-Sacrement and the Hopital l'Enfant-Jesus are the teaching hospitals of the university.

The neuropsychiatric clinics have been introduced within the last few years. Services are available to in and out-patients alike. None of these hospitals has a separate psychiatric unit.

The Hotel-Dieu in Quebec City operates two clinics - one a neuropsychiatric clinic and the other a mental health clinic used particularly to screen mental deficient children within the school system. The assistant psychiatrist at the University also serves on the hospital staff.

At the Hopital St-Sacrement, facilities are available for modern treatment including electroshock and psychotherapy. In 1950, 361 cases were registered. Of these, 283 received treatment as in-patients in hospital wards while 78 were treated through the out-patient clinic. Services are being expanded gradually as more facilities and staff become available.

The Hopital St-Francois d'Assise and the Hopital l'Enfant-Jesus both have neuropsychiatric clinics with modern facilities. Both serve out-patients as well as in-patients. In 1950, the Hopital St-Francois d'Assise provided treatment for 96 in-patients and 74 out-patients; the other hospital for 171 in-patients and 313 out-patients.(1)

Few data are available concerning the out-patient services provided by the Jeffery Hale Hospital. Personnel added to the staff through federal health grant aid include a part-time psychiatric consultant who serves all hospital departments.(2)

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(1) No later data are available.
(2) This hospital reports an out-patient neuropsychiatric clinic but no evidence is available concerning any out-patient work.

The remaining out-patient departments are located outside Quebec City at Chicoutimi and Levis. The Hotel-Dieu de Chicoutimi has a separate psychiatric unit for electro and insulin shock therapy as well as an out-patient clinic and treats roughly the same number of in and out-patients.(1) Caseload of the Hotel-Dieu de Levis is somewhat smaller.(2) Similar services, including electroshock, are available to both in and out-patients.

In addition to the hospital clinics directed by a psychiatrist which have been described above, a psychiatric nursing service is maintained at the tuberculosis hospital, the Sanatorium Ross. However, this clinic is available to in-patients only.

B. Non-Hospital Services Associated with Laval University

Most of the services provided outside the hospitals are of a mental health counselling nature. The psychiatric nursing service which operates the clinic in the Sanatorium Ross also serves the Sanitary (local health) Unit of Gaspe. In the Rimouski area one full-time psychiatric nurse provides consultative and educational services through the Family Service and Health Unit. Other counselling centres include the Medico-Social Centre and the Social Rehabilitation Centre, both in Quebec City, and the Rehabilitation Society of Sherbrooke, Inc., in the city of Sherbrooke.

In January, 1952, Laval University organized a Centre Medico-Social in Quebec City. This centre makes available free diagnostic and treatment services to children with emotional or behaviour problems residing anywhere in the city or in any organized health unit in the province. It is operated by a board which includes the medical director of the centre (a psychiatrist) and the executive secretary (a social worker). The centre provides a full complement of medical, psychological and social services for children aged 2 to 18 years. Cases may be referred by health units, welfare agencies, mental health clinics in general hospitals, clergymen, teachers or parents. In 1952, the centre served 502 cases.

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(1) In 1950, 225 in-patients and 286 out-patients received psychiatric care.

(2) In 1950, 70 in-patients and 45 out-patients were treated.

The Social Rehabilitation Centre, also in Quebec City, is a diagnostic and rehabilitation clinic for delinquent children and adults. It was established early in 1946 under sponsorship of Laval University School of Social Work, with the help of a grant from the Conseil des Oeuvres de Quebec. Later a medical section was added with federal aid. Services provided at present (1954) include medical, psychological and welfare care; however, only a small percentage of the cases require psychiatric attention.

The Rehabilitation Society of Sherbrooke, Inc. was established to help maladjusted children but also serves adults, especially indigent cases (1). Services include psychotherapy, psychometric testing, placement in institutions, corrective teaching and follow-up work by the welfare section. Cases are referred by a variety of agencies and individuals.

C. Other Out-Patient Services

The only mental health clinic in eastern Quebec not directly affiliated with a university is the Medico-Social Institute at Three Rivers. This mental health clinic for children of the Three Rivers area was established in 1947 and has been expanding its work steadily as staff became available. Services include diagnosis and treatment of mental disorders in children and preventive work involving parent education. Emphasis is placed on adequate environment for the out-patient.

Ontario

As in other provinces, mental health services have expanded rapidly since World War II. In 1948, community clinics were limited chiefly to the Toronto area; elsewhere, the existing services were provided by travelling clinics centered at some mental hospitals but organized by the province. Today, a network of mental health clinics serve the more densely populated parts of the province.(2) Clinics continue to be operated by some mental hospitals, but general hospitals, provincial and local governments and community agencies play a much larger role than six years ago.

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(1) This clinic is distinct from the home for mental defectives discussed elsewhere in this report.

(2) See map opposite page 66.

In 1953, the province of Ontario had 7 psychiatric units in general hospitals, 17 community out-patient departments in mental hospitals, 6 community clinics operated by municipal health departments chiefly for child guidance and 4 travelling clinics teams operating out of mental hospitals but, in addition to their own area, serving the population of 22 cities and towns remote from stationary hospital clinics.

To obtain a clear picture of the network of clinics, psychiatric units and hospitals in Ontario today, it is simpler to examine them by hospital regions. A list of out-patient departments, stationary and travelling clinics is shown in Appendix III. The map opposite page 66 should also be studied.

Region 1: Southwestern Ontario

Hospital Region 1, in southwestern Ontario, had a population of around 750,000 in 1950. It includes the cities of London and Windsor. London is the site of the University of Western Ontario and while the influences of medical faculties on mental health services are less direct in other provinces than in Quebec, they are nonetheless present in varying degree and the psychiatric out-patient services of this Health Region are centered chiefly in London.

The Victoria General Hospital in London has had a 15 bed psychiatric unit as well as an out-patient department since 1944. Although the out-patient clinic cares for patients of any age group, the services are directed toward adults. St. Joseph's, another general hospital, is planning a 33 bed psychiatric unit and an out-patient department. Construction is now well underway (1954).

Out-patient treatment facilities are also available at The Ontario Hospital, London. This mental hospital carries on an advanced treatment and rehabilitation program which includes an out-patient service. In addition, it operates a travelling clinic, financed by the province, which provides diagnostic and consultative services in London itself and in Sarnia, Woodstock, Chatham, Windsor, Stratford and Owen Sound.

Since 1949, the Windsor City Health Department has conducted a child guidance clinic serving the 200,000 population of Windsor and Essex County Psychometric testing, guidance, consultative and treatment services are provided for preschool children.

At St. Thomas the Ontario Hospital operates an out-patient clinic for patients of all ages.

Region 2: Hamilton and the Niagara Peninsula

The population of Region 2 is slightly smaller than that of Region 1, numbering roughly 700,000 in 1950. It includes the city of Hamilton.

The Hamilton City Health Department has operated a general purpose mental health clinic since 1948 for its 200,000 population The cost is shared by the city and the federal government. Services include consultation to the juvenile and family courts, therapy for adult psychiatric patients, child guidance and general community educational work. In addition to the work of this clinic, services are provided at the Hamilton General Hospital by private psychiatrists.

The Ontario Mental Hospital at Hamilton has an out-patient department and operates a travelling clinic. The travelling clinic serves Hamilton itself and also the cities of Guelph, Wentworth, Simcoe, Milton, Brantford, Shelburne and Dunnville.

For some years, a district travelling clinic has worked in the Niagara District It is operated by a Consultant Psychiatrist on the staff of the Ontario Health Department. This was linked with the Lincoln County Health Unit and through the clinic out-patient services were made available at the general hospitals of St. Catherines, Welland and Niagara Falls.

In 1953, the St. Catherines' General Hospital established a 22 bed psychiatric unit and all-purpose clinical services are now provided for both in and out-patients.

Region 3: Central Ontario

Hospital Region 3, with its population of over 2 million, is considerably larger than any other in Ontario. It includes the metropolitan area of Toronto.

The major short-term therapy centre is the Toronto Psychiatric Hospital, already discussed. It provides both in-patient and out-patient services of all types for both adults and children.

In addition to the Toronto Psychiatric, however, there is a network of mental health clinics throughout the city. The Toronto General Hospital, Wellesley

Division, and the Toronto Western Hospital have both established psychiatric wards and out-patient departments. The 32 bed unit in the Toronto General was opened in 1949; the 38 bed unit in the Toronto Western, in 1953.

Other hospitals in Toronto have limited clinical facilities provided by staff physicians. These include St. Joseph's, St. Michael's and the Mount Sinai hospitals. At St. Michael's a 30 bed psychiatric unit is under construction.

Extensive mental health facilities for children are available in Toronto. The most complete medical services are provided by the Toronto Hospital for Sick Children. Its Clinic for Psychological Medicine functions as a part of the hospital's out-patient service. The Toronto Mental Health Clinic, a complete diagnostic and treatment centre, serves both children and adults. It is administered by voluntary citizens and financed by the Community Chest and the Canadian Mental Health Association.

Since 1951, primary responsibility for child guidance for public school children has been assumed by the Toronto Board of Education. A full-time psychiatric and guidance service is provided. The Toronto City Department of Health maintains a Division of Mental Health which operates a preschool guidance centre, provides consultation and counselling for children in the separate schools and cares for adults referred by public health workers. In addition, the Toronto Family Court maintains a full-time psychiatric service for children under sixteen years. Its functions are chiefly diagnostic and investigatory, however.

Further services for children are associated with research projects. The Institute of Child Study, a part of the University of Toronto, studies child development and gives parent education; consultation is free to all day nursery schools in the Toronto area. The Forest Hill Village project, a comprehensive research and teaching program which began some years ago under sponsorship of the university, provides both diagnosis and therapy to children during the course of investigations.

Communities adjacent to Toronto have instituted their own child guidance services. The York Township Health Department opened a child guidance clinic in 1949,(1) which serves children of all ages. As a part

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(1) The population in 1950 was around 95,000.

of its health program the East York-Leaside Health Unit also administers a similar clinic which diagnoses and treats habit, personality and behaviour disorders in children and offers consultative and educational services to parents, schools, health and welfare agencies.

Although Toronto provides the major facilities in Hospital Region 3, certain supplementary services are available in other central Ontario communities. Limited services to a 200,000 population are provided by the Peterborough Civic Hospital. The Kitchener-Waterloo General Hospital also has a psychiatric out-patient department.

Region 4: East-Central Ontario

Hospital Region 4, with a population of 250,000, includes the city of Kingston. The Ontario Hospital, located at Kingston, provides a travelling clinic team which serves Kingston itself and Belleville, Perth, Almonte, Renfrew and Pembroke. The mental hospital and the Kingston General Hospital each maintain an all-purpose, out-patient clinic.

The Sunnyside Centre, Kingston, is a residential clinic for emotionally disturbed children. It is administered by a voluntary society but serves as a teaching clinic for Queen's University.

Region 5: Eastern Ontario

Region 5, with a population of around 500,000, includes the city of Ottawa. Recently both the Ottawa Civic Hospital and the Ottawa General Hospital[1] have established psychiatric units and out-patient departments for both children and adults. The clinic at the Civic Hospital is administered by the Ontario Department of Health, while that at the General Hospital is administered by the hospital superintendent.

The Ontario Hospital at Brockville provides a travelling clinic for Brockville, Ottawa, Cornwall, Alfred and Morrisburg.

Region 6: Northern Ontario

The northern part of Ontario has a less concentrated population of roughly 350,000 with few larger cities. The only permanent clinic is located in the

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(1) The psychiatric unit at the Ottawa Civic Hospital contains 9 beds; at the Ottawa General, 30 beds.

Sudbury General Hospital. This all-purpose clinic, opened in 1950, provides consultative and diagnostic services to courts and gaols, guidance to the schools, diagnostic and both short-term and long-term out-patient psychiatric treatment, as well as a public education program. All services are administered by the city health department. A psychiatric ward of 35 beds is also under construction at the Sudbury General Hospital.

A travelling clinic, operated by the provincial Department of Health, visits the communities of Timmins, Kirkland Lake and Sudbury once each year. Its services are chiefly consultative.

Region 7: Northwestern Ontario

Northern Ontario, including the Thunder Bay area, has a scattered population of around 200,000. It lacks community mental health services except those provided in minimum amount by the staff of the Ontario Hospital at Port Arthur.

Manitoba

In the province of Manitoba, mental health services are provided on an out-patient basis at the following centres:

Hospital Out-patient Departments

Winnipeg Psychopathic Hospital
Winnipeg General Hospital
St. Boniface Hospital
Children's Hospital

Travelling Clinics		Child Guidance Clinics
Brandon	Rivers	Winnipeg School Board
Minnedosa	Flin Flon	Selkirk
Neepawa	The Pas	Brandon
Dauphin	Souris	
Virden		

Hospital out-patient services are available mainly in Winnipeg; however, both the Brandon and the Selkirk Hospitals for Mental Diseases have Out-Patient Departments which hold periodic clinics,(1) which serve both ex-patients of the hospital and out-patients. No

(1) In the Brandon hospital, appointments were limited to 2 days per week in 1952.

stationary clinics are held elsewhere in Manitoba but a travelling clinic from Brandon serves Minnedosa, Neepawa, Dauphin, Virden, Rivers, Flin Flon, The Pas and Souris, as well as Brandon itself.(1) Child guidance clinics are operated in Winnipeg, Brandon and Selkirk. The Child Guidance Clinic of Greater Winnipeg has been in operation for many years.

Hospital Out-Patient Departments

Of the four hospital out-patient departments, the Winnipeg Psychopathic Hospital handles by far the largest number of cases. The growing demand for psychiatric services is shown in the steep rise in caseload which increased from 544 cases in 1951 to 705 cases in 1952.

The out-patient clinic serves both children and adults. In 1952, cases were referred by a variety of organizations - the city and provincial health departments, the Children's Aid Society, the Family Bureau, the Juvenile, Family and other courts, Alcoholics Anonymous, the Winnipeg General and St. Boniface hospitals, private physicians and others. Cases from the Juvenile and Family Courts and from the City and Provincial Police Court are seen in increasing numbers in this out-patient department. Services provided are similar to those described in an earlier section.(2) The clinic is staffed by the regular hospital personnel.

The psychiatric clinic in the Winnipeg General Hospital serves both in-patients and out-patients. Some "disturbed" and alcoholic cases are admitted to the wards from the out-patient department, and, if in need of prolonged care, are sent to one of the mental institutions. Cases referred by the Children's Aid Societies, Public Welfare Family Bureau and other child care agencies are frequently sent to this out-patient department; most cases involving chronic alcoholism are also seen at this hospital.

The St. Boniface Hospital is the only general hospital in Winnipeg with a psychiatric unit for in-patients. Approximately 10 beds are set aside for this purpose. The service, initiated in 1950, is in charge of a trained part-time psychiatrist and a psychiatric nurse, both paid through federal aid. Therapy includes insulin and electroconvulsive shock and group therapy but patients in a critical condition are usually transferred to a mental institution. In 1953, 212 patients received care in this unit.

(1) See map opposite page 70.

(2) See section "Psychiatric Hospitals".

In addition to in-patient services, the St. Boniface Hospital has an out-patient department which treated 96 cases in 1953. Shock therapy and other modern treatment are available, the same as for in-patients. All resident physicians and internes in the general hospital are required to serve for a period in the out-patient clinic.

The Children's Hospital provides both in-patient ward care and out-patient care for emotionally disturbed children.(1) In 1953, 2 psychiatrists, 2 psychologists-in-training and 2 physicians acquiring experience in child psychiatry, a full-time psychiatric nurse, 2 playroom supervisors and 2 speech therapists participated in the dual program. Close liaison is maintained with the Greater Winnipeg Child Guidance Clinic, and staff members may serve both clinics, as needed. All facilities for treating emotionally disturbed children are available. A play therapy room is used by both in-patients and out-patients.

Travelling Clinics

A travelling clinic, operating from Brandon, provides clinical mental health services in Brandon itself as well as Minnedosa, Neepawa, Dauphin, Virden, Rivers, Flin Flon, The Pas and Souris Services provided include psychometric and clinical testing.(2) These clinics are conducted by personnel from the Brandon Hospital for Mental Diseases. The clinic team also does the testing of in-patients at the Hospital and of hospital staff.

Child Guidance Clinics

In addition to the services provided for children in the hospitals discussed above, out-patient child guidance clinics are also conducted by the Brandon and Selkirk Hospitals for Mental Diseases and by the Child Guidance Clinic of Greater Winnipeg which has been operated by the Winnipeg School Board for many years. Of the hospitals already discussed, the Winnipeg Psychopathic Hospital has, during the past years, handled most of the juvenile delinquency cases; however, this situation is changing as more and more emotionally

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(1) In 1953-54, 44 in-patients required 885 treatment days in the hospital; no figures are available for the out-patient department.

(2) There is no record of other than diagnostic work - chiefly psychometric - and guidance.

disturbed children - whatever their problems - are being referred to the Child Guidance Clinic of Greater Winnipeg or to the Psychiatric Clinic at the Children's Hospital

The Child Guidance Clinic of Greater Winnipeg has a long history. It was maintained for many years by the Winnipeg School Board, as a school guidance clinic providing psychiatric and psychological services, speech training and remedial reading courses to school children of Winnipeg proper. In 1951, however, the clinic was reorganized and is now operated jointly by the Winnipeg School Board and the Provincial Department of Health. The Director is on the staff of the provincial government. Services were expanded to become both more extensive and more intensive: The area covered was extended to include suburban Winnipeg.(1)

Emphasis is placed on prevention in all the work of the clinic. Visiting teachers visit the schools to screen out children with academic or personal problems, and refer such cases to the clinic. Parent-teacher groups and teachers receive instruction on how to detect incipient problems. A survey of children with problems has been made on an experimental basis in one school.

Remedial work in reading, arithmetic, etc. is designed to avert future problems resulting from failure. Children with speech or hearing defects receive attention. Special classes are conducted for mentally retarded children and also for the gifted.

Cases may be referred to the psychiatric service of the clinic by schools, welfare agencies or by other departments of the clinic. Case work is done by a psychologist who administers tests as needed and assists with placing the child in the appropriate class.

In addition to diagnosing and treating the child, educational work is stressed. Radio programs and illustrated discussions are popular techniques in the public education area. Field training is provided for students of the University of Manitoba, as needed. The

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(1) According to the 1952 Annual Report, shortage of trained personnel has made it impossible to fill all positions created under the federal grant.

clinic also maintains a Central Registry of all cases.(1)

The Child Guidance Clinic at the Selkirk Hospital for Mental Diseases was established in 1948 under the Health Grants Program, as a joint project of the hospital and the Selkirk Health Unit. It provides clinical services to Selkirk and towns in the surrounding area. The clinic team consists of a part-time psychiatrist, part-time social worker, and full-time psychometrist and stenographer. Staff shortages in the mental hospital have curtailed the activities of the clinic since a part of the clinic team also serves the hospital.

Services provided by the Child Guidance Clinic at Brandon are also hampered by lack of staff. In 1952, it was reported that due to the shortage of skilled personnel, for the first time in 20 years psychometrists had failed to carry out a testing program in Brandon schools.(2)

Saskatchewan

At the end of 1953, Saskatchewan had 3 full-time and 6 part-time mental health clinics. In addition out-patient services were provided by the psychiatric hospital in Regina(3) and a child guidance service was operated by the Regina School Board. Clinics are located as follows(4):

Full-time Clinics	Part-time Travelling Clinics	
Saskatoon, MacNeill Clinic	Yorkton	Assiniboia
Regina	Swift Current	Weyburn
Moose Jaw	Prince Albert	North Battleford

(1) During the three months from Sept. 1, 1951 to Nov. 30, 1951, 51 children received complete psychiatric study, 381 children psychometric tests and guidance, 2,728 were screened for speech and hearing problems and 502 received speech therapy. The clinic Reading Department surveyed academic failures of 110 students.

(2) Annual Report, 1952, p. 173.

(3) The Munroe Wing of the Regina General Hospital; see discussion under Psychiatric Hospitals. A second psychiatric unit will be opened in the new University Hospital in Saskatoon in 1955.

(4) See map opposite page 72.

The full-time clinics are administered by the Psychiatric Services Branch of the provincial Department of Public Health. Each has a clinic team consisting of two full-time psychiatrists, a psychologist, one or two social workers and secretarial staff. Their function is three-fold: (a) to provide diagnostic and consultative services to practising physicians in the community, (b) to provide short-term treatment for selected cases, and (c) to provide an educational service for teachers, nurses, social workers, physicians and others in related fields.

The six part-time clinics are directed by psychiatrists from the mental institutions, the psychiatric hospital and the Regina Mental Health Clinic. The Yorkton clinic is served by the Regina clinic, the Prince Albert clinic by the MacNeill clinic in Saskatoon, the Weyburn clinic by staff from the Saskatchewan Hospital at Weyburn, the North Battleford clinic by the Saskatchewan Hospital at North Battleford, the Swift Current and Assiniboia clinics by staff from Regina. Functions of the part-time clinics are similar in scope to the full-time clinics except that treatment services are not provided.

The MacNeill Clinic in Saskatoon was established in 1949. It serves the city of Saskatoon with a population of 56,000 and the surrounding district for a radius of 100 miles. Diagnostic and consultative services are provided to local physicians, with emphasis placed on child guidance and early treatment. Cases are referred by the Department of Social Welfare, practising physicians, schools and the Saskatoon Children's Rehabilitation Centre; follow-up work and rehabilitation services are provided for patients discharged from the mental hospitals. Electroconvulsive therapy is administered on an out-patient basis, and occupational and recreational therapy are available. Staff includes 2 clinic psychiatrists, 1 psychologist, 2 social workers, 1 registered nurse who also serves as occupational therapist, and a secretarial staff of 3 persons.

In 1951, a part-time clinic was established at Prince Albert as a branch of the MacNeill Clinic. Visits are made regularly by the Saskatoon team.

The Regina Mental Health Clinic, administered by the provincial Department of Public Health, is an out-patient clinic of the Regina General Hospital. Services include consultation, diagnosis, psychotherapy, play therapy and speech therapy. Much of the work is child guidance. Personnel consist of 2 psychiatrists, a social worker, a psychologist, speech therapists and clerical staff.

The Moose Jaw clinic was opened in 1952 with assistance from the Mental Health Grant. Before this time the city had been served by a part-time clinic from the Saskatchewan Hospital at Weyburn. The new clinic is staffed by two full-time psychiatrists, a social worker, a psychologist and a stenographer. It is accommodated at the regional health centre, thus facilitating co-operation between clinic staff and the regional public health staff. Its program is similar to those in Regina and Saskatoon.

Like many other mental health clinics in Canada, the Moose Jaw Clinic was supported entirely through federal grants during 1953-54, its first year of operation. However, during 1954-55, the provincial government will assume 25 percent of the cost, and an additional 25 percent during each successive year until the full cost is borne by the province.

Alberta

Guidance clinics have been operated in Alberta since 1929 under direction of the provincial Division of Mental Health. The first were travelling clinics operating from the mental institutions at Ponoka, Edmonton and Red Deer. In 1947 a full-time clinic was established in Calgary to serve southern Alberta and the following year another was opened at Edmonton to serve the northern part of the province. Since that time the system of travelling clinics has been extended to include 22 centres. At present (1954), clinics are located as follows(1):

Stationary Full-Time Clinics

Calgary Edmonton

Part-time Travelling Clinics

Barrhead	Holden	Spirit River
Cardston	Lethbridge	Stettler
Castor	Medicine Hat	Vegreville
Drumheller	Peace River	Vermilion
Fairview	Ponoka	Wainwright
Grande Prairie	Red Deer(2)	Wetaskiwin
High River	Rimbey	
High Prairie	Rocky Mountain House	

(1) See map opposite page 74.

(2) Red Deer also has a guidance clinic with a permanent office for appointments. A clinic team from the Training School for Mental Defectives services this clinic at request.

Each clinic is staffed by a psychiatrist, a psychologist and a psychiatric social worker. Follow-up work is done by local public health personnel, who may also refer cases to the clinics.

During 1950, the clinics handled 1,629 new cases involving roughly 10,000 contacts with patients, parents, social agencies and a variety of sources of referral. Of these cases, 79 percent were 19 years of age or under. The majority of cases were referred to the clinics by schools, private doctors and community agencies, in the order listed.(1)

In 1953, two psychiatric units were placed in service. One, at the University of Alberta Hospital in Edmonton has accommodation for 18 patients; the other, in the Calgary General Hospital, has 20 beds. Both units are under the jurisdiction of the hospitals concerned but the provincial government contributes to their operating costs on a per patient basis. Patients are admitted on a voluntary basis and are treated by a psychiatrist attached to the hospital staffs.

British Columbia

Child Guidance Clinics, under provincial auspices, have been operating in British Columbia since 1932 when a part-time clinic was established in Vancouver.(2) The system of Child Guidance Clinics, which now extends over a wide area of the province, is administered by the provincial Mental Health Services, which also bears the total cost. Health Departments in the metropolitan areas of Vancouver and Victoria have separate Divisions of Mental Hygiene which provide consultation and guidance to schools and local health unit personnel. Clinics are located as follows(3):

Out-Patient Departments

Vancouver General Hospital
Royal Jubilee Hospital, Victoria

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(1) Annual Report, 1952, p. 182

(2) Although the British Columbia mental health clinics are called Child Guidance Clinics they serve a substantial number of adults. In 1952-53, clinics served 1,574 adults and 7,772 children.

(3) See map opposite page 76.

Stationary Clinics

Metropolitan Health Committee of Greater Vancouver

Vancouver: Provincial child guidance clinic headquarters and clinic.

Victoria: Victoria-Esquimalt Board of Health Clinic

Victoria: Provincial Child Guidance Clinic

Delinquency Unit for Young Offenders

Travelling Clinics

Abbotsford	Grand Forks	Prince George
Chilliwack	Trail	Duncan
Haney	Nelson	Nanaimo
Kamloops	Creston	Courtenay
Salmon Arm	Cranbrook	Port Alberni
Vernon	Powell River	Nakusp
Penticton	Prince Rupert	

Provincial Child Guidance Clinics. The province sponsors two full-time stationary clinics located in Vancouver and Victoria. From the clinic headquarters in Vancouver, a travelling psychiatric team visits mainland points as frequently as the demand arises. The same holds true of the Victoria team, which serves Nanaimo, Courtenay and other points on Vancouver Island. Since 1950, a third clinic team, staffed by the Vancouver clinic but financed through federal grants, works with the Juvenile Court and the Boys' and Girls' Industrial Schools. Social workers serving in these Child Guidance Clinics are employed by the Social Welfare Branch of the provincial department and this phase of the service is supervised by the Provincial Supervisor of Psychiatric Social Work.

In the Vancouver area clinics are held regularly at the Children's Hospital, the Health Centre for Children, a paediatric unit of the Vancouver General Hospital, and the Western Society for Physical Rehabilitation Centre.

In 1952-53, the provincial clinics registered 1,132 cases. Of these, 43 percent were referred by social agencies; 18 percent by medical and health agencies including public health nurses and hospitals; 18 percent by the courts and the Boys' and Girls' Industrial Schools; 9 percent by parents and relatives and 6 percent by private physicians. Most of the cases were pre-adolescents, with a substantial percentage of preschool age.

Metropolitan Mental Hygiene Services. The Mental Hygiene Division of the Metropolitan Health Committee of Greater Vancouver is under the direction of a psychiatrist who gives general supervision and direction to health unit directors, public health nurses and teachers. The clinical services are largely limited to school children and university students. Close liaison is maintained with the provincial Child Guidance Clinic to which cases requiring prolonged or intensive treatment are referred.

The Victoria-Esquimalt Board of Health conducts a similar program, directed especially to school and community groups. Both Metropolitan Services receive federal grants.

Other psychiatric services, not included above, are provided by the psychiatric units in the Vancouver General Hospital and the Royal Jubilee Hospital in Victoria. The Crease Clinic of Psychological Medicine, discussed earlier, also offers out-patient services.

MENTAL HEALTH PERSONNEL

Personnel employed in the mental health field include a variety of professions. Closely allied with psychiatry are the professions of nursing, social work and psychology. Each of these professions has developed a psychiatric specialty within its own field - psychiatric nursing, psychiatric social work and clinical psychology. Other professions in the psychiatric team include occupational therapy and recreational therapy. In addition, large numbers of non-professional workers are employed in mental hospitals.

For many years there has been a shortage of mental health workers and with the recent emphasis on the development of preventive and active treatment services the demand for personnel has increased. To meet these needs, training facilities across the country have expanded, particularly since federal grants for professional training were introduced in 1948, and some increase in the supply of mental health personnel has been achieved.

Employment of Personnel

As no reliable information is at present available on personnel employed in community clinics, statistics of employment must be limited to those on the staff of mental institutions. The Dominion Bureau of Statistics Annual Report on Mental Institutions lists the number and type of personnel employed in mental institutions. Table XIII records these statistics.

On December 31, 1952, there were 15,877 persons employed including 471 physicians, 857 other professional persons, 3,659 registered, graduate and student nurses, 5,895 aides and attendants, and 4,995 other administrative and maintenance personnel. Personnel in primary contact with patients totalled 10,882 or 68 percent of all employees. The relationship between numbers of personnel and patients under care is illustrated by Table XIV, which shows the number of patients per employee for selected categories of personnel. The average number of patients per employee in 49 provincial mental hospitals in 1952 was 3.7. Including part-time medical staff and both graduate and undergraduate interns there was one medical staff member for every 125 patients. In the case of nursing staff (including graduates), students, aides and attendants, Table XIV shows 6.1 patients per employee.

TABLE XIII. PERSONNEL EMPLOYED IN MENTAL INSTITUTIONS:
December 31, 1952 (1)

Class of Employees	Canada	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
Medical Superintendents	46	1	1	1	1	9	18	4	4	3	4
Medical Staff (2)											
Physicians on ward duty	258	1	2	9	9	45	98	16	29	19	30
Other medical staff	213	3	2	13	2	63	92	15	9	10	4
Matrons or Superintendents of Nurses	79	3	1	18	2	19	18	4	5	6	3
Nursing Staff (3)											
Registered Nurses	1,007	22	2	34	15	297	511	22	18	43	43
Graduate Nurses	1,470	-	-	5	-	15	102	156	310	118	764
Student Nurses	1,182	-	-	37	-	117	128	157	365	238	140
Aides and Attendants	5,895	179	48	206	182	1,440	2,910	157	89	261	423
Other Professional Staff											
Graduate Social Workers	67	1	-	2	2	14	20	2	2	3	21
Psychologists, Psychometrists	82	1	-	2	3	10	44	4	5	3	10
Occupational Therapists	148	18	1	-	-	12	53	19	13	6	26
Other Professional	560	11	2	25	6	203	143	30	39	30	71
Administrative Staff (4)	754	17	7	44	23	137	293	38	67	60	68
Other Maintenance Staff	4,116	81	37	216	106	1,125	1,275	209	384	371	312
Total Staff	15,877	338	103	612	351	3,506	5,705	833	1,339	1,171	1,919

(1) Includes 71 mental hospitals, representing 99 percent of mental hospital bed capacity.
(2) Includes full-time and part-time physicians, graduate medical interns and undergraduate medical interns.
(3) Excludes affiliate nurses.

Source: Dominion Bureau of Statistics, Mental Institutions, 1952, Table 2.

TABLE XIV. NUMBER OF PATIENTS PER EMPLOYEE: PROVINCIAL MENTAL INSTITUTIONS, 1952, BY PROVINCE [1]

Province	Patients in hospital at year end	No. of patients per employee			
		Administration	Medical [2]	Nursing [3]	Total Staff
Newfoundland	779	37.1	194.8	3.9	2.3
Prince Edward Island	303	33.7	75.8	6.1	2.9
Nova Scotia	500	20.8	62.5	3.2	1.6
New Brunswick	1,686	64.8	153.3	8.6	4.8
Quebec	15,959	110.8	161.2	9.8	5.1
Ontario	17,738	59.1	101.9	5.4	3.5
Manitoba	3,378	73.4	109.0	6.9	4.1
Saskatchewan	4,572	60.2	120.3	5.8	3.4
Alberta	3,780	54.8	130.3	5.7	3.2
British Columbia	4,970	69.0	155.3	3.7	2.6
Canada	53,665	68.0	124.8	6.1	3.7

(1) Data cover 49 provincial mental institutions, excluding 16 county and municipal institutions in Nova Scotia, 4 private institutions and 2 federal institutions.

(2) Includes full-time and part-time staff exclusive of medical superintendents, and includes medical interns.

(3) Includes registered, graduate and student nurses as well as aides and attendants; affiliate nurses are excluded.

Source: Dominion Bureau of Statistics, Mental Institutions, 1952, Table #3, OTTAWA, Queen's Printer, 1954.

The provincial health surveys, carried out in 1948, revealed shortages of qualified psychiatric personnel in all provinces and, despite expanded training programs and increases in expenditure for personnel, the shortage continued to exist for certain categories in 1954. The growth of treatment services, requiring more professional personnel and the increase in the number of patients in institutions has tended to offset the growing numbers of psychiatrists, nurses and other psychiatric workers.

The extent of the shortage of psychologists, psychiatric social workers and occupational therapists may be seen from a survey conducted by the federal Mental Health Division in 1952. Provincial health departments in nine provinces supplied information on the number of persons employed and the number of positions vacant. Twenty-six out of 128 positions for psychologists, 31 out of 135 positions for social workers and 48 out of 103 positions for occupational therapists were not filled at that time. An increasing number of these classes of personnel have been employed in mental institutions since 1952.

Training of Personnel

The education of mental health workers is centred in the universities, mental hospitals and psychiatric hospitals and training facilities in these institutions have been steadily expanding. Federal grants to institutions for equipment and salaries of instructors and the provision of bursaries and other assistance for personnel undergoing training have played a substantial part in this growth.

Psychiatrists. Education in psychiatry, following medical internship, usually consists of two years training at an accredited university followed by at least two years of supervised study in an approved setting, usually a mental or psychiatric hospital. Certification as a specialist in psychiatry is obtained through successful examination by the Royal College of Physicians and Surgeons (Canada).

Psychiatric training in the Atlantic Provinces is offered by Dalhousie University, Halifax. In 1949 this university commenced post-graduate instruction in psychiatry in co-operation with the Nova Scotia Mental Hospital, the Victoria General Hospital, the Children's Hospital, Dalhousie Public Health Clinic and the Hospital for Mental and Nervous Diseases at St. John's, Newfoundland. The training program is sponsored by the four Atlantic Provinces.

McGill, Laval and Montreal Universities all have facilities for specialist training in psychiatry. At McGill, training facilities for a 4-year course are available at the Allen Memorial Institute, the Verdun Protestant Mental Hospital, the Montreal General, the Royal Victoria Hospital, the Children's Memorial Hospital, the Ste. Anne de Bellevue Veterans' Hospital and the Mental Hygiene Institute. At Laval, affiliated hospitals include the Hopital Saint-Michel-Archange and the Roy-Rousseau Clinic; the University of Montreal is associated with the Hotel-Dieu de Montreal, the Hopital de la Misericorde, Hopital Notre-Dame, Hopital Sainte-Justine, and Hopital Saint-Jean-de-Dieu.

In Ontario, the University of Toronto, the University of Western Ontario and Queen's University give post-graduate training in psychiatry, while the Ontario (Mental) Hospitals and the Toronto Psychiatric Hospital provide in-hospital training. The focus of the university training program in Toronto is the Toronto Psychiatric Hospital; facilities are also available at the Sunnybrook Veterans' Hospital, Toronto General Hospital, the Hospital for Sick Children and the Ontario Hospitals at Toronto and New Toronto. The Ontario Hospitals at Kingston and London are the teaching hospitals for Queen's University and the University of Western Ontario. In 1954, nearly every Ontario Hospital had physicians on staff who were working toward the certificate in psychiatry of the Royal College of Physicians and Surgeons; a large number of these were receiving fellowships under the National Health Program.

Effort has been directed toward providing the University of Manitoba with facilities and staff for post-graduate training in psychiatry and with the recent appointment of a full-time Professor of Psychiatry to the Faculty of Medicine the program is expected to get underway in September, 1954. In Saskatchewan a four-year training program leading to certification in psychiatry, is carried out in the provincial mental hospitals as well as at the Munroe Wing, Regina General Hospital. The Provincial Mental Hospital at Ponoka, Alberta offers a similar program. Physicians in British Columbia take psychiatric training at McGill and Toronto Universities and carry out their in-hospital training in the British Columbia mental institutions.

Psychologists. Increasing use is being made of clinical psychologists and psychometrists in community clinics, psychiatric units in general hospitals and mental hospitals. Qualifications may include a doctoral or masters degree in psychology. In Canada, the main training centres are the University of Toronto and the

University of Western Ontario; 49 of 59 psychologists trained with federal assistance during 1949-53 were trained at these two centres. Other Universities offering training in clinical psychology are McGill, Montreal, Dalhousie, Ottawa, Queen's and British Columbia.

Psychiatric Social Workers. The training of psychiatric social workers was stimulated by the introduction of the National Health Program. During the first five years, 130 persons received bursaries to assist their training; of these, 40 were trained at McGill University and 44 at the University of Toronto. Others attended the Maritime School of Social Work, Halifax, through a joint project sponsored by the four Atlantic Provinces. Other training centres include the schools of social work operated by Laval University, University of Montreal, St. Patrick's College, Ottawa and the University of British Columbia.

Psychiatric Nursing. Several types of training in psychiatric nursing care is given in all provinces, chiefly by mental institutions: student nurses in general hospitals affiliate with mental hospitals for a short course in psychiatric nursing; registered nurses are offered post-graduate courses in psychiatric nursing in mental hospitals; student nurses in mental hospitals affiliate with general hospitals to obtain other experience; mental hospitals in Saskatchewan, Alberta, and British Columbia train their own psychiatric nurses and all provinces offer some course for the education of psychiatric aides and attendants.

At the Hospital for Mental and Nervous Diseases, St. John's, Newfoundland, a five-month course is given for psychiatric nursing aides and attendants. The course is given twice yearly, and in 1951 there were 34 graduates. A one-month course is provided for affiliated nurses; an average of 10 students are under instruction at a time, with instruction heavily concentrated on psychiatry and psychiatric nursing. Refresher courses for graduate nurses are also given.

In Prince Edward Island, the Falconwood Mental Hospital provides a two year course of training for psychiatric nursing attendants; about five attendants graduate each year. In 1954, provincial Public Health Nurses received a 2½ month course in mental health nursing at Dalhousie University, Nova Scotia. This course is given jointly by the Dalhousie School of Nursing and the Department of Psychiatry at the Dalhousie Medical School. When trained, these nurses work in community mental health clinics.

The Nova Scotia Mental Hospital operates a Training School for Nurses at which a three year course in psychiatric nursing is given. In March, 1951, there were 34 student nurses. Senior students are affiliated with the Victoria General, Halifax Children's Hospital, Grace Maternity Hospital and the Nova Scotia Sanatorium for non-psychiatric nursing education.

In New Brunswick, a training course for psychiatric attendants was introduced in 1953 at the Provincial Hospital, Lancaster. Eight students were enrolled for a nine-months course; it is the intention of the Hospital to enlarge the scope of this training and to introduce additional courses for other categories of staff in the future. Graduate nurses from the Provincial Hospital have completed post-graduate psychiatric nursing training at McGill and Toronto Universities.

In Quebec, schools of nursing are operated at three mental hospitals; Verdun Protestant Hospital and Hopital Saint-Jean-de-Dieu in Montreal, and Hopital Saint-Michel-Archange in Quebec. The Hopital Saint-Michel-Archange has a School of Nursing affiliated with Laval University which gives training to Registered Nurses' standards. The Hospital also gives a refresher course in psychiatric nursing to graduate nurses of general hospitals who later work in clinics in general hospitals. The Verdun Protestant Hospital is affiliated with McGill University; instruction in psychiatric nursing is given to graduate nurses, undergraduate nurses and to both male and female attendants. The Hopital Saint-Jean-de Dieu is affiliated with the University of Montreal and offers similar training. General hospitals giving psychiatric training to their undergraduate student nurses include St. Mary's, the Royal Victoria Hospital, Montreal General and Hopital Sainte-Justine in Montreal, Hopital General in Verdun and Hopital Saint-Joseph at Trois Rivieres.

Since August 31, 1951, all student nurses in Ontario have been required to take three months psychiatric nursing training in an affiliated mental hospital. In 1951, five of the Ontario (mental) Hospitals offered a three-year training course to Registered Nurses' standards, 12 months of which were spent in a general hospital and three months in a children's hospital. In its graduate course in clinical supervision, the University of Toronto includes a 12-month course in psychiatric nursing.

In Manitoba, a School of Nursing is operated at the Brandon Mental Hospital. Student nurses from three affiliated general hospitals are given a three-month course in psychiatric nursing while the Brandon mental hospital provides a three and a half year course leading to the status of registered nurse with a diploma in psychiatric nursing. A two-year course is offered to men and women leading to a diploma in psychiatric nursing. A six-month post-graduate course for registered nurses and an in-service training program for male and female nursing aides also form a part of the educational program. The Selkirk mental hospital gives training in psychiatric nursing to both nurses and attendants while the Winnipeg Psychopathic Hospital provides instruction for under-graduate nurses from affiliating hospitals.

Since 1947, the Saskatchewan mental hospitals and training school have offered a three-year course leading to registration with the Saskatchewan Psychiatric Nurses Association, an association officially recognized by the Provincial Legislature. A substantial number of these psychiatric nurses have been graduated and have provided much of the nursing services needed to meet the expanded treatment program in Saskatchewan's mental institutions. Student nurses from general hospital training schools affiliate at the Munroe Wing, Regina General Hospital, for a three-month period. In view of the shortage of qualified psychiatric social workers and occupational therapists arrangements have been made to provide training for graduate psychiatric nurses in these fields. Under the direction of fully-qualified personnel it is believed that these nurses would do very effective work.

In Alberta, psychiatric nursing courses are conducted at the Provincial Mental Hospital, Ponoka. For under-graduates, there is a four year course which includes two years of training at the mental hospital and two years affiliation in general nursing. The Ponoka hospital also accepts short-term affiliates from general hospitals and offers an 8-month post-graduate course in psychiatric nursing. In 1950 the teaching program included 19 student nurses and 34 student attendants in under-graduate training; 10 registered nurses taking the eight-month graduate course. In addition, 22 public health nurses spent two weeks at the Hospital and 24 general nurses had two-month affiliation courses. The Provincial Mental Hospital, Edmonton, also offers a three-year course leading to a certificate in psychiatric nursing. This is open to all male and female nursing staff with the necessary educational prerequisites.

All psychiatric nursing training in British Columbia is carried out in a central school at the Provincial Mental Hospital, Essondale. Two and three-year courses of instruction are given leading to a diploma in psychiatric nursing[1] and a course is offered to graduate registered nurses leading to a diploma in psychiatric nursing. Student nurses in general hospital training schools affiliate with the Provincial Mental Hospital, Essondale. The length of the course for such students is two months.

(1) A Council of Psychiatric Nurses in British Columbia is empowered to authorize licenses for psychiatric nurses with credentials from a School of Psychiatric Nursing approved by the Council.

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MENTAL HEALTH EDUCATION

In most countries, one of the great stumbling-blocks to progress in the mental health field is the prejudice which continues to surround mental illness. To eliminate this prejudice, great emphasis is placed on mental health education in Canada. In the adult field, many educational media are used; in the schools, emphasis is usually placed on the establishment of good habits of adjustment. The following discussion is divided into two parts: Public Education, and School Services. The first of these describes the media currently in use in the public education field; the second deals chiefly with special training for children who do not profit by the services of the ordinary public school.

PUBLIC EDUCATION(1)

Several national and provincial organizations participate in public mental health education in Canada. The Department of National Health and Welfare, the national office and provincial divisions of the Canadian Mental Health Association and the provincial Departments of Health, Welfare, and Education share in this work. A large number of professional organizations, scientists, service clubs, press, radio and private citizens co-operate with the national or provincial organizations in all provinces.

Mental Health Division, Department of National Health and Welfare

Since its inception, the federal Mental Health Division in co-operation with the Information Services Division has carried on an educational program, assembling and developing educational materials for use of field workers. Printed materials are distributed through the provincial Health Departments; films and

(1) This section is only a brief sketch of the work in progress in the educational field. No attempt has been made to describe the work in individual provinces, although some provinces have more comprehensive programs than others. Readers interested in greater detail are referred to publications by the Canadian Mental Health Association and by the Mental Health Division of the Department of National Health and Welfare.

filmstrips may be purchased from the National Film Board or borrowed through local film libraries, provincial health departments or the Canadian Film Institute in Ottawa.

Among the films which have been produced through the co-operative effort of the Mental Health Division and the National Film Board are the "Ages and Stages" series, depicting behavioural development of a normal child in a normal home, the "Mental Mechanisms" series dealing with mental illnesses -- their causes, possible preventive measures and treatment. A film "Shyness" was produced as a result of prolonged study in this problem. Three filmstrips "Preparing Your Child for School", "Preparing Your Child for Medical and Dental Care" and "Discipline", are available.

Literature compiled and distributed by the Mental Health Division includes illustrated discussions on such topics as Obedience, Feeding Habits, Fear, Temper, Sex, Bedwetting, Thumbsucking, Nervous Habits, Lying and Stealing, Stuttering, Shyness, Baby Talk, Preparing Your Child for School, Preparing Your Child for Hospital, Discipline, Epilepsy, Mental Health Clinics, The Backward Child and many others. A section of a 208 page book Up The Years From 1 to 6 deals with children's behaviour during the designated age range. Posters and display materials are under continuous revision and new materials are released regularly.

The Mental Health Division also serves as a clearinghouse for technical information and relays it to the provinces. Since October, 1953, a newsletter "Canada's Mental Health", published monthly, is distributed to the provincial Divisions, mental hospitals and clinics, health educators and other interested persons. This contains items of practical or professional interest such as accounts of education programs, workshops, training institutes, surveys and research. Discussion guides designed to accompany audio-visual materials are prepared by the Division.

The Department of National Health and Welfare sponsors a weekly radio program "Here's Health". Many of its 15 minute talks are aimed at improving public understanding of mental health problems.

Canadian Mental Health Association

The Canadian Mental Health Association has actively participated in mental health education for well over thirty-five years, securing and maintaining a

close working relationship with various voluntary organizations and liaison officers in every province. Today, (1954) the seven provincial divisions are sharing in this work, while provincial committees are active in the three provinces lacking divisions. Close liaison is maintained with the federal Mental Health Division in order to supplement rather than duplicate its activities and to maintain continuity of the overall program.

Communication media include the circulation of minutes of all meetings of the National Board, the Scientific Planning Council, the provincial Boards of Directors and the provincial Scientific Planning Committees. A news bulletin, "The C.M.H.A. Reporter", is published quarterly and a leaflet "Program Ideas" is distributed monthly to key personnel in the mental health field. Reports of pilot studies and surveys are also circulated. Staff members from the national office visit the provinces several times a year to strengthen their programs in various ways.

The Canadian Mental Health Association serves in a consultative capacity to both the Canadian Broadcasting Corporation and the National Film Board. Each Tuesday night the CBC broadcasts a half-hour program dealing with mental health. Publicity is provided through brochures distributed by the Association's national office in co-operation with the provincial divisions, government departments and various committees. The 1953-54 broadcast series covered such topics as "In Search of Ourselves", "As Children See Us" and "What's on Your Mind". In the film field, the Association collaborates closely with the federal Mental Health Division and the National Film Board, sometimes in an advisory capacity and sometimes initiating film strips or movies. Lists of available films are compiled for "Canadian Film News"; American, British and French films are appraised and, if deemed suitable, are brought to the attention of field personnel.

Lay membership has been invited by the Association since its formation - indeed, lay personnel helped to form it. All members are informed of new developments and new opportunities for service through quarterly newsletters, public meetings and other media. To encourage lay participation an annual "Mental Health Week" was inaugurated during the first week of May, 1951. Public addresses, newspaper and magazine articles, radio commentaries and distribution of literature are gradually resulting in an increasing public awareness. Well over 400 press items pertaining to Mental Health Week appeared in 200 newspapers in 1953; television was tried for the first time in that year.

Among other activities designed to foster public interest and participation are the "Open Door Information Services" for persons with mental problems, fund-raising projects in Saskatchewan and Ontario, and a program of visiting "forgotten" mental patients which involves regular activities by volunteer workers. In 1953, the Saskatchewan division - the oldest of the provincial branches - raised approximately $14,000 of its $19,643 budget through a door-to-door canvassing campaign during Mental Health Week. In Ontario, a "Penny Round Up" which involved a total of 1,490 working hours donated by volunteers,(1) contributed well over a million pennies. These are significant milestones because they represent the first attempts of lay organizations to raise funds for mental health work by direct appeal to the public.

Canadian Broadcasting Corporation

The Canadian Broadcasting Corporation has been active in public mental health education since 1948. Its program series includes "Life with the Ferguson's", "The Laycock Series", "Ways of Children" and addresses by various speakers. A series entitled "Here's Health", developed in co-operation with the Department of National Health and Welfare deals with mental as well as other health problems. Television facilities have been made available to the Canadian Mental Health Association on occasion since 1951.

National Film Board

As mentioned above, the National Film Board has prepared several films in the mental health field. At the end of 1953 the following films were available: "Mental Symptoms Series", "Breakdown", "Condition Improved", "Feelings of Hostility", "Feelings of Rejection", "Feelings of Depression", "Over-Dependency", "Shyness", and "What's on Your Mind". These are distributed throughout the United States as well as in Canada.

Parent Education

The Institute of Child Study of the University of Toronto, and the Mental Hygiene Institute of McGill University have been providing training for parent education leaders for several years. The Canadian Home

(1) Summary of Annual Reports of the provincial divisions: Canadian Mental Health Association, 1953.

and School and Parent-Teacher Federation, Incorporated, a national organization affiliated with the Canadian Mental Health Association, includes a variety of mental health topics in its Home and School programs. In Quebec, the Ecole de Parents, is active in bringing home and school closer and in strengthening family life. Other associations such as the Canadian Association for Adult Education contribute directly and indirectly. The National Council of Women have Mental Health Convenors in every community where their organization exists. The National Council of Jewish Women helps to support the Canadian Mental Health Association financially and participates actively in educational work through study groups; they have also organized Senior Citizen's Clubs in six centres. Women's Institutes in Ontario and Quebec have become keenly interested in mental health work and in Ontario, 1953, participated in the Penny Round Up.

Men's clubs such as the Rotarians, Kiwanians, Kinsmen and Progress Clubs play a role in public mental health education in many centres. Their activities range from supplying film libraries and equipment to visiting mental hospitals and to sponsoring Mental Health Week.

Experiment in Teacher Training

One of the projects initiated by the Canadian Mental Health Association and supported through the federal Mental Health Grant was a five-year experimental training program for teachers. Although this project was directed toward mental health education in the schools, it also influenced public education. Thirty-five selected teachers were each given one year's training in the mental health field and then returned to their own provinces to assume responsibility for co-ordinating mental health and education.(1) An objective evaluation of this training program was begun in 1952, with financial assistance from the Carnegie Foundation. In the Fall of 1953, the course was re-established under the Institute of Child Study, University of Toronto. Nine teachers registered at that time - six from Thailand through arrangement with UNESCO and one each from Alberta, Saskatchewan and Ontario.

(1) Many of the special teachers mentioned in the section "School Services" were trained under the Forest Hill Village project.

The Committee on Public Education

One of the most important but frequently least publicized activities in any educational field is the evaluation of techniques and materials currently in use. It was to answer the question "Are the educational media accomplishing the purpose for which they were designed?" that a Committee on Public Education was appointed in 1952 to serve as a subcommittee of the National Advisory Committee on Mental Health. Members of this continued Committee on Public Education include representatives from the Department of National Health and Welfare, the Canadian Mental Health Association, the Allan Memorial Institute and the Mental Hygiene Institute of McGill University. To date, the major effort has been concentrated on appraising the effectiveness of diverse techniques for changing public attitudes.

Educational Work of Clinics

Despite the increasing activities of various agencies in public education, there can be little doubt that the most effective educational work is being done in the community clinics across Canada. This work has been mentioned indirectly in almost every section of this report. Medical personnel in clinics and hospitals, public health nurses, psychologists, social workers and many others share in this work. Perhaps the recovered patient and his family play the greatest role in gradually breaking down the barriers of prejudice for he is convincing proof that like physical ailments his illness may also be cured.

SCHOOL SERVICES

Detecting early symptoms of intellectual, emotional or personality deviation is a problem for those who live and work most closely with a child. Accordingly, the task falls not only on parents and family physicians but also on teachers and health workers in schools across Canada.

At the present time there is little uniformity in the types of mental health services provided for children in the several provinces or within any province; wide variations depend on the population of a community and on the sources available for referrals.

All provinces provide some child guidance but as yet these services are limited chiefly to the more densely populated urban areas.(1) Therapeutic facilities for children with emotional and personality disturbances are rarely provided by the school systems; usually a child with such problems is referred to the nearest child guidance or all-purpose clinic.(2) However, a few large cities able to support school health units do provide more direct help. Intellectually retarded children may be sent to the training schools for the mentally defective or to opportunity classes maintained by the school systems in most provinces, depending on the degree of retardation.(3) Parents' groups and other voluntary organizations are also becoming more and more active in sponsoring day schools for children of inferior ability who are not admitted by the public schools.

Within the schools, the teacher frequently becomes the major case-finder. Most elementary school teachers in Canada are high school graduates with one or two additional years of training at a Teachers' College or Normal School. Teacher training institutions provide some orientation in the mental health field through courses in educational psychology, child psychology and/or mental hygiene. In all provinces, the chief aim of this orientation is not to qualify teachers for therapeutic work but to create an awareness of mental health problems, and of what constitutes normal adjustment at various stages of growth and development, to point out ways and means of fostering sound adjustment through a wholesome school and home environment, to enable teachers to detect incipient signs of abnormality and to provide information regarding sources of referral for problems which cannot be solved by the home or school. Perhaps equally important is the objective of creating an awareness of the impact of the teacher's personality and adjustment on the children under his care, thus causing him to examine his own ways of handling personal and classroom problems.

Secondary school teachers are usually university trained, with specialization in education. The university faculties and colleges of education demand at least one course in educational psychology and frequently offer additional training in introductory psychology,

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(1) See the maps of the various provinces.

(2) These clinics have been discussed in the section "Local Hospital and Clinic Services".

(3) Institutional facilities have been discussed in the section "Institutional Care for Special Groups".

psychology of personality, child psychology and adolescent psychology. However, apart from educational psychology, these courses are often electives and hence not all potential teachers enrol in all classes.

In-service training for both elementary and high school teachers is available through summer courses at several universities. Courses in mental hygiene and in child psychology are usually offered.

School boards of most of the larger urban centres in Canada employ one or more specialists in vocational guidance. Guidance programs commonly include psychometric testing, interest inventories and appraisals of personality both by interview and by the simple paper and pencil techniques; few guidance personnel are trained in the use of the Rorschach, the Thematic Apperception Test or other projective techniques. Guidance is based on a consideration of test results coupled with school achievement records, medical records when available and an overall view of the child's behavior and relationships with others. Case conferences involving the school principal, psychologist, social worker, teachers concerned, and school medical personnel are being used increasingly wherever school health personnel are employed. If no constructive approach can be devised by these teams or if the problem is too complex for school resources, the case is referred to the nearest clinic. Parallel, though not identical procedures are followed in all provinces.

Many areas in Canada have small schools with limited teaching staff and no special health service for the children. In these areas, the public health nurse and local medical practitioner play major roles in detecting mental health problems and, in co-operation with parents, in ensuring that treatment is made available. In some areas, the social worker may be responsible for home contacts, for arranging therapy and for manipulating the home environment, as needed. Public health nurses and social workers both obtain university training in mental health problems.

Some provinces and provincial areas have advanced more rapidly than others in providing special services for children whose abilities deviate from the normal range. To date, special classes for gifted children are rare but many of the larger city schools operate opportunity classes for retarded children who are not

institutionalized. Services, not discussed in other sections are summarized briefly below.(1)

Newfoundland

Newfoundland has no special mental health services for children. Special cases are referred by the family doctor to the Hospital for Mental and Nervous Diseases at St. John's. There is no school psychologist; the only psychological services available in the province are located at the hospital.

Prince Edward Island

In addition to services mentioned in other sections of this report, Charlottetown has four opportunity classes operated by the school system and one class sponsored by a parent's group.

Nova Scotia

Classes for retarded children are provided by the school systems in two cities, Halifax and Sydney. Halifax has 15 opportunity classes while Sydney operates 5 special classes. In addition, the Junior League and the Home and School Association of Halifax maintain a speech therapy clinic. Guidance counsellors function in most of the province's schools with over four teachers on staff.

New Brunswick

Opportunity classes are operated by the school boards in four New Brunswick centres: Fredericton, Saint John, Moncton and Campbellton. Fredericton also has a day training school for children in the 50 to 60 I.Q. range. This is maintained by the Beta Sigma Phi Sorority. In Saint John, the five opportunity classes operated by the schools admit only children in the 50 to 75 I.Q. range. The city schools also maintain five classes in remedial education. Guidance counsellors with part-time teaching duties are employed by a number of schools including one in Edmundston, one in Grand Falls, one in Fredericton, two in Moncton and twelve in Saint John (4 at high school level and 8 in elementary schools).

(1) For a comprehensive review of school mental health services, see the publication "School Mental Health Services in Canada": Mental Health Division, Department of National Health and Welfare, July, 1954. Material for this section has been abstracted from the above source.

Quebec.

In the province of Quebec, special facilities for children are concentrated in the cities of Montreal and Quebec. Both the Catholic and Protestant School Boards in Montreal maintain opportunity classes for retarded children; Quebec City has special classes for the "pedagogically deficient"(1). Full-time guidance counsellors are employed in Montreal, Quebec, Three Rivers and Sherbrooke.

In Montreal, the Mont Providence Hospital maintains a special school for French Catholic children in the 50 to 70 I.Q. range. A similar school on St. Lawrence Boulevard gives training to 60 French and English children. Two special schools--one in the Snowdon area and one in Lachine--are operated by the Association for the Help of Retarded Children, Incorporated. The School Board of Westmount maintains a mental health consultant (a psychiatrist) who carries on a research and prevention program. Twelve psycho-technicians visit Montreal schools to administer psychometric tests; a staff of 200 nurses, supplied by the city, also assists with mental health work.

Ontario

In Ontario a variety of special classes for the mentally retarded and the physically handicapped are provided by the Auxiliary Education Division of the Department of Education. Most of the larger cities have opportunity classes for children under 13 years of age with I.Q.'s over 50; Toronto alone has 35 such classes. Other widely distributed types of instruction include handicraft classes, remedial education classes, home instruction for the physically handicapped, hospital classes for children in hospitals or sanatoria and special classes for children with visual or auditory impairments.

More limited in distribution are the speech correction classes. These are located at Windsor, London, Kitchener, Hamilton, Toronto, Brantford, Ottawa and Kingston. Other limited services, at present in the experimental stage, are the advancement classes for gifted children; two of these have been developed in London - one for junior and one for senior students.

(1) It is not clear whether these special classes are for french-speaking children only, nor have we evidence on the I.Q. range admitted either in Quebec or in some Montreal classes.

The Ontario Schools assume responsibility for providing services only for children with I.Q.'s of 50 or more. Since no provision (other than the hospitals and training schools discussed elsewhere) has been made by the province for lower-grade defectives, branches of the Parents' Council for Retarded Children have begun to organize classes for children whose I.Q. is less than 50. The provincial government pays $250.00 per child per year for approved courses.(1) During 1953-54, such classes were held at Simcoe, Brantford, Hamilton, London, Woodstock, Toronto, Niagara Falls and Peterborough. More local branches of the Council are being organized and the expansion of this type of work is expected to be fairly rapid.

A large number of Ontario schools have guidance counsellors. In the city of Toronto, the school board has organized a division, The Child Adjustment Services, which is headed by a psychiatrist and staffed by 2 half-time psychiatrists, 11 full-time and 3 part-time psychologists, 2 full-time psychiatric social workers and a clerical staff. This service operates a headquarters clinic and 4 clinics in other parts of the city, servicing a population of roughly 80,000 children in the public and secondary school system. The 18,000 separate school children are referred to the mental health clinic at the City Health Department.

Manitoba

Special services for children in Manitoba are limited almost entirely to Winnipeg. The metropolitan area has 30 opportunity classes maintained by the schools and one operated by a parents' group. Special provision is made for children with speech and hearing defects, reading or other academic handicap or with emotional problems. The extensive services provided by the Child Guidance Clinic of Greater Winnipeg have been described elsewhere.(2)

Outside Winnipeg, services are supplied to children as well as adults by the stationary or travelling mental health clinics and by public health nurses. An opportunity class is maintained by parents of retarded children at Flin Flon.

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(1) See also "Services for Mental Defectives" and "Local Hospital and Clinic Services".

(2) See section "Local Hospital and Clinic Services".

Saskatchewan

In Saskatchewan, Mental health services for children are provided chiefly through the all-purpose clinics and by the public health nurses. Teachers are given some orientation in mental health work, and teacher-psychologists are located as follows: two in Regina and one each in Swift Current, Moose Jaw, Saskatoon and Weyburn. Guidance counsellors are available in Regina and Saskatoon.

Saskatoon has five special classes for retarded children in the 50 to 80 I.Q. range. Advancement classes for gifted children were begun as early as 1931. These admit students with I.Q.'s of 133 and over. At the present time (1954) there are two such classes in Saskatoon.

The Saskatchewan Department of Education places considerable emphasis on mental health instruction in the schools. In the elementary school curriculum of grades I to VIII, stress is placed on the high positive - correlation between physical and mental health and on the importance of learning to work and play with others. In the high school curricula both guidance and general health education are emphasized; elementary courses in psychology are suggested electives for junior and senior matriculants.

Alberta

As mentioned earlier, child guidance clinics have been operated in Alberta since 1929 under direction of the provincial health department. The Department of Education also participates in mental health work through teacher training, and close co-operation is maintained between the clinics and the schools.

Guidance counsellors are found in most city school systems and teacher-liaison officers, trained in Toronto, are employed in Calgary and Edmonton. Calgary also has a school psychologist, while Edmonton maintains a mental health teacher.

Opportunity classes for the mentally retarded are located in Edmonton, Calgary, Lethbridge and Medicine Hat. Special training is also provided for children with visual or auditory impairment.

British Columbia

Special services for children in British Columbia tend to be concentrated in the Vancouver and Victoria

areas, although clinics are held at other points. Services provided by the school systems are closely integrated with the clinics to which disturbed children are referred. Four liaison officers work within the Vancouver School System and two psychologists are responsible for the 25 special classes maintained for retarded children and for the three sight-saving classes.

Like Saskatchewan, British Columbia places considerable emphasis on personal development in the general school curricula. Guidance is stressed for all schools and there are about 175 guidance counsellors in the province - roughly one counsellor (or two half-time) for every 250 secondary school pupils in the province.

Vancouver Island is served by the clinics operating in and out of Victoria. Opportunity classes are available only in the Victoria School System.

FORENSIC PSYCHIATRIC SERVICES(1)

Psychiatric services for individuals detained by law have become more readily available in recent years. The increase in the number of mental health clinics, out-patient departments in general and mental hospitals and the greater number of skilled psychiatric personnel have placed some type of psychiatric service within reach of all courts and reform institutions.

Juvenile courts generally refer offenders with psychiatric complications to child guidance clinics or to out-patient departments of general or mental hospitals. Training schools for juvenile offenders may either purchase the services of consultant psychiatrists or are visited by mobile clinics.

Courts for adult offenders are also making increasing use of psychiatric services. Magistrates' courts may refer cases to mental hospitals for examination or, alternatively, the examination may be made in the jail. Prisoners accused of capital crime are nearly always examined by psychiatrists and the results made available to the Crown and the Defence. Finally, prisons and jails for adult offenders may utilize the services of psychiatric teams in the treatment and rehabilitation of inmates.

Newfoundland

In the province of Newfoundland, a juvenile and family court is located at St. John's. This court refers cases to the out-patient department of the Hospital for Mental and Nervous Diseases. Similarly, the Hospital may appraise cases with psychiatric involvement which come before the provincial magistrates' courts. In such cases, certification by two doctors is prerequisite to admission to the mental hospital. The hospital out-patient department makes services available to the training schools for boys and girls while the provincial mental health educationalist has been carrying out a program of staff instruction.

Newfoundland has established a Division of Corrections with the aim of developing educational and treatment programs directed toward both the prevention of delinquency and the rehabilitation of inmates of

(1) Data for this section have been abstracted from the Mental Health Divisions's bulletin "Services for Courts and Reform Institutions", published July, 1954.

correctional institutions. The Division includes a youth and an adult guidance authority with each group including a psychiatrist.

Prince Edward Island

In Prince Edward Island the county courts serve as juvenile and family courts. The services of a community mental health clinic in Charlottetown are available to all courts. When cases suspected of psychiatric involvement appear before a magistrate's court, they may be remanded for a period of a week in order that an examination may be made through the provincial mental health division. Prisoners in need of psychiatric care may be committed to the provincial mental hospital by warrant of the Attorney-General.

Nova Scotia

Juvenile courts in Halifax and Sydney refer cases to the mental health clinics in their respective cities. When necessary, cases may also be referred to a community mental health clinic at Digby. Individuals appearing before a magistrate's court may be referred to psychiatrists on the staff of the provincial Department of Health. Persons convicted of sexual offences are either sent to the Nova Scotia Hospital at Dartmouth on a 30-day warrant for observation or a psychiatrist or psychologist may examine the prisoner in jail. Mentally ill prisoners may be committed to the mental hospital on a Lieutenant-Governor's warrant.(1)

In Halifax, cases before the magistrate's court may be referred to the psychiatric out-patient department of the Victoria General Hospital. Arrangements for mental examination are made by the city health officer. Two medical certificates are necessary for committal - one from a psychiatrist on staff with the out-patient clinic and one from a physician employed by the city health department.

The provincial Department of Welfare employs a psychologist who provides services to the reform institutions, children's aid societies and district offices of the Department.(2)

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(1) In such cases, the patient is liable to face the original charge when he is discharged from the hospital.

(2) Such offices are located at Digby, Antigonish and Halifax where there are no children's aid societies.

New Brunswick

Juvenile courts at Moncton and Saint John, New Brunswick, have access to the mental health facilities in those cities. Where there are no juvenile courts, the magistrates' courts perform equivalent functions and refer cases to the above-mentioned clinics. Magistrates' courts dealing with adult offenders refer cases to clinics at Moncton, Saint John and Fredericton. Prisoners may be detained in a mental hospital for a 60-day observation period; however, committal requires certification by two physicians

The superintendent of the Boys' Industrial Home at Saint John is a psychologist. His staff includes another psychologist as well as a psychiatric social worker. The services of a psychiatrist are made available through the mental health clinic at Saint John Other reform institutions utilize the services of the clinics at Moncton and Saint John. On discharge, juvenile delinquents may be referred to a clinic where a psychiatric social worker assumes responsibility as probationary agent.

Quebec

In the province of Quebec, the courts for juvenile offenders are known as social welfare courts. Four such courts operate in Montreal, Quebec City, Three Rivers and Sherbrooke. Sources available for referral are the Child Aid Clinic in Montreal, the Social Readaption Service in Quebec City, the Medico-Social Centre in Three Rivers and the Rehabilitation Centre in Sherbrooke. Services of psychiatrists, psychologists and psychiatric social workers are provided by all of these clinics. In rural areas, juvenile offenders appear before district judges who are assisted by the diocesan social services.

The Quebec Department of Social Welfare and Youth operates 14 youth probation schools in the province. Schools are provided for both Catholic and Protestant children. Of approximately 3,000 children, aged 6 to 18 years, who attended these schools in 1953, the majority were admitted through the social welfare courts. Some of the probation schools are visited by travelling mental health clinics. A team including a psychiatrist and psychologist from the Mental Hygiene Institute in Montreal make regular visits to both the Boys' Farm and Training School at Shawbridge and the Girls' Cottage School at Saint Bruno - both located near the city.

Adults appearing before a magistrate's court in Quebec City or Montreal who are considered in need of psychiatric appraisal are detained in jail for examination by a mental hospital psychiatrist. Outside these cities, cases may be transferred by the court to Quebec or Montreal for examination. Prisoners may also be remanded to Bordeaux prison hospital for observation and diagnosis.

Ontario

In 1953, there were roughly 33 juvenile and family courts in Ontario. Many of them have access to mental health facilities, either through travelling clinics or through the Ontario (mental) Hospitals or local psychiatric units. The juvenile and family court in Toronto has its own permanent clinic, staffed by a psychiatrist, psychologist and social worker. Offenders under the age of sixteen are sent to Training Schools operated by the Department of Reform Institutions where mental health services are provided by the staffs of the Ontario Hospitals. The Ontario Training Schools for Boys at Cobourg and Guelph and the Ontario Training School for Girls at Galt employ full-time psychologists and social workers. The school at Galt is visited weekly by a consultant psychiatrist.

Adult courts make use of local facilities wherever they are available. If local services are lacking, the accused is detained in jail pending examination by local physicians and may then be transferred to a mental hospital. A prisoner may be remanded to a mental hospital for observation for a period not exceeding 60 days; if determined mentally ill, he is then certified and remains in the hospital.

A judge or magistrate may send an offender to the Toronto Psychiatric Hospital for observation.(1) This may be done on request of the prosecution, the defence or the presiding judge. Ten beds are available at the hospital for such cases. Examinations are made by members of the Department of Psychiatry of the University of Toronto. Following the observation period, a report on the patient's mental status is submitted to the court which determines sentence. On certification by two psychiatrists, cases diagnosed as psychotic are transferred to a mental hospital; others may be placed on probation for treatment at an out-patient clinic.

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(1) Cases referred to this hospital are generally involved in minor offences, not indictable.

Persons charged with murder or rape may be referred by the Attorney-General's department to a chief psychiatric consultant employed by the Ontario Department of Health and to three assistant psychiatric consultants from the mental hospitals.

Psychologists and/or counsellors are employed in Ontario reform institutions. Psychometric and personality tests and interest inventories are given on admission. Other psychiatric services are provided by the Ontario Department of Health or by the mental hospital staffs, as needed.

Manitoba

Juvenile and family courts convene in Winnipeg, St. Boniface, Brandon and Dauphin; in other centres magistrates' courts perform parallel functions. In Winnipeg, the Juvenile and Family Court usually refers cases to the Winnipeg Psychopathic Hospital but both the Winnipeg and St. Boniface courts refer minors to the Child Guidance Clinic of Greater Winnipeg. Elsewhere in the province, courts utilize the services of local mental health facilities and travelling clinics. Inmates of juvenile detention homes may be referred to the out-patient department of the Winnipeg Psychopathic Hospital.

Magistrates' courts use the services provided by the provincial health department. Cases with psychiatric involvement may be remanded for examination at either the out-patient department of the Winnipeg Psychopathic Hospital or in jail; if diagnosed as psychotic, individuals may be transferred from the hospital to a mental institution on order of the provincial psychiatrist

Provincial jails also have access to services provided by the Winnipeg Psychopathic Hospital, the Portage la Prairie training school or the mental hospital at Brandon.

Saskatchewan

Saskatchewan has one juvenile court judge who serves the entire province, visiting various centres as needed. Where necessary the court utilizes the services of mental health clinics.

All reform institutions for adult and juvenile offenders are under the jurisdiction of the Correction Branch of the provincial Department of Social Welfare Reform schools for juveniles may utilize the psychiatric services provided by the Munroe Wing of the Regina General Hospital

An accused or convicted person may be transferred from jail to a mental hospital for an observation period not exceeding 30 days, by Order-in-Council. Magistrates may order a defendant to a mental hospital for observation prior to disposal of the case; however, certification by two doctors is necessary for committal to a mental institution. Drug addicts and alcoholics may be admitted voluntarily to a mental hospital for a period not exceeding one year.

In cases of capital crimes, the accused may be examined by a psychiatrist from the provincial psychiatric services; in all such cases, a report is submitted to the court. For other serious charges the Crown will obtain psychiatric appraisal if requested to do so by the defence.

Provincial jails have access to the services of mental health clinics and some jails have their own staff psychologists. In-service staff training - including courses in elementary psychology, behavioural dynamics and treatment methods - is carried on by all correctional institutions. As a part of their training, staff members also attend seminars in the mental hospitals.

Alberta

In Alberta, juvenile courts convene in Calgary and Edmonton. Elsewhere in the province magistrates function as juvenile court judges. Juvenile courts make use of facilities offered by both stationary and travelling mental health clinics. Offenders from outlying areas are frequently brought to the Calgary and Edmonton clinics for appraisal and treatment. Homes for juvenile offenders also utilize the services of clinics, when necessary.

A large number of court referrals are made to the Provincial Mental Institute at Edmonton. Temporary detention for psychiatric examination may be made for 7 or 30 days, or for a longer period if desirable. Results of such examination are made available to both the Crown and the defence. Staff of the mental hospital at Ponoka provide similar services for cases detained in the jails at Calgary or Lethbridge, pending disposition by the courts.

Prisoners in provincial jails may also be examined by psychiatrists from the provincial mental hospitals.

British Columbia

In British Columbia, a full-time juvenile court operates in Vancouver. Cases are referred by this court to the Vancouver Child Guidance Clinic. A similar clinic in Victoria serves the magistrate's court which deals with juvenile offenders in that city. Boys' and Girls' industrial schools have social workers on staff and refer cases to child guidance clinics, when necessary. Probation officers are responsible for cases referred by the courts.

In Vancouver and Victoria, the magistrates courts may remand a prisoner on a 30-day warrant for observation by a private psychiatrist. Elsewhere in the province, magistrates' courts may remand a prisoner for psychiatric examination in Vancouver. If a prisoner is diagnosed as mentally ill, he may be committed to a mental institution on certification by two physicians under a magistrate's warrant. Prisoners charged with capital crime may be detained in a mental hospital for psychiatric examination.

Oakalla Prison, the provincial jail, has a full-time psychiatrist, a psychologist and three social workers on staff. The part-time services of a private psychiatrist are also available.

Federal Penitentiaires

In Canada, penitentiaries are the responsibility of the federal government. They are administered by the Department of Justice through the office of the Commissioner of Penitentiaries.

Penitentiary inmates who develop symptoms indicative of mental illness of a protracted nature may be certified as mentally ill. A request is then made to provincial mental health authorities to have the patient admitted to a provincial mental institution. Patients suffering from less severe emotional disturbances may be referred to a penitentiary psychiatrist or to a consultant psychiatrist (1).

(1) Part-time psychiatrists are employed at the penitentiaries in British Columbia, Saskatchewan, Manitoba and Ontario. The penitentiary at Kingston, Ontario, has a psychiatric ward of 9 beds; treatment available includes psychotherapy, electroshock therapy, occupational and recreational therapy.

All Canadian penitentiaries have a psychologist or classification officer on staff.(1) These officers screen new admissions and recommend suitable vocational training.

(1) Classification officers are university graduates, preferably with special training in psychology and with experience in psychometrics.

RESEARCH IN THE MENTAL HEALTH FIELD

Research in the mental health field is of recent origin in Canada. Although an Associate Committee on Medical Research was formed by the National Research Council of Canada as early as 1938, its efforts were directed toward other aspects of medical investigation and few projects touched upon the problems of mental health. A few studies were carried out by the universities with financial aid from non-government sources.

In 1948, under the National Health Program, the Department of National Health and Welfare inaugurated a special grant, the Public Health Research Grant, of which small amounts have been used to support investigations in the mental health field. In addition, provisions for research were made under the Mental Health Grant. During the first few years of the National Health Program well over $900,000 of this money was spent for a variety of studies. The gradual growth of the research program is indicated by the annual expenditures shown in Table XV.

While the Department of National Health and Welfare was encouraging exploration in some areas, the National Research Council was also setting aside substantial yearly sums for research and over the four-year period from 1949-50 to 1952-53 spent over $160,000. The Defence Research Board and the Department of Veterans' Affairs financed studies related to mental health as it pertains to national defence and to war veterans. The amounts spent by each of these federal agencies are also shown in Table XV.

All Canadian provinces participate in medical research and most of the provinces have shared in investigations pertaining to mental health. The larger provinces whose universities, mental health divisions and hospitals were older, better established and/or equipped for research purposes have perhaps contributed most in this line up to the present time, but many of the smaller or less well populated provinces are also building up research programs. The extent of financial participation under the Mental Health Grant alone is shown in Table XVI.

Table XVII indicates the number of projects approved each year under the Mental Health Grant, and is

TABLE XV. AMOUNTS EXPENDED ON MENTAL HEALTH RESEARCH BY THE FEDERAL GOVERNMENT, BY AGENCY AND FISCAL YEAR

Sponsoring agency	1948-49	1949-50	1950-51	1951-52	1952-53(1)	Total
	$	$	$	$	$	$
Dept. of National Health and Welfare:						
(1) Mental Health Grant	4,850	51,555.87	174,522.79	291,669.80	399,163.85	921,762.31
(2) Public Health Research Grant		137.93		15,102.82	39,565.50	54,806.25
National Research Council		40,000.00	40,000.00	40,800.00	40,800.00	161,600.00
Defence Research Board			23,215.00	16,000.00	15,000.00	54,215.00
Dept. of Veterans' Affairs						39,290.00
						1,231,773.56

(1) Preliminary figures.
(2) Only a rough estimate is available of Department of Veterans' Affairs expenditures.

Source: Department of National Health and Welfare, 1954.

TABLE XVI. AMOUNTS EXPENDED FOR RESEARCH UNDER THE MENTAL HEALTH GRANT: BY PROVINCE AND FISCAL YEAR

Province	1948-49	1949-50	1950-51	1951-52	1952-53*	Total by Province
	$	$	$	$	$	$
Newfoundland		2,116.15	5,034.36	2,046.98		9,197.49
Prince Edward Island						
Nova Scotia			5,817.46	21,316.79	22,607.78	49.742.03
New Brunswick	1,000.00	2,000.00		436.38	3,355.71	6,792.09
Quebec			62,884.66	89,583.20	116,845.63	269,313.49
Ontario	3,850.00	43,942.05	85,475.66	152,020.54	213,764.15	499,052.40
Manitoba		3,497.67	3,532.90	2,742.60	2,940.40	12,713.57
Saskatchewan					13,762.37	13,762.37
Alberta						
British Columbia			11,777.75	23,523.31	25,887.81	61,188.87
Total by Year	4,850.00	51,555.87	174,522.79	291,669.80	399,163.85	921,762.31

* Preliminary figures for 1952-53

Source: Dept. of National Health and Welfare, Mental Health Division: adopted from "Research Projects under the Mental Health Grant", July, 1953.

again indicative of the growth of the program.[1] Projects should not be added, for most of them were continued over several years, as shown in Table XVIII, and many of them are still in progress. While the federal government has financed a considerable amount of Canadian research since 1948, the universities, mental and psychiatric hospitals and clinics and the provincial Mental Health Divisions have done most of the work. This distribution of effort is indicated in Table XVIII.

A rough division of labour has been observed among the various federal research-sponsoring agencies. Usually, but not invariably, the National Research Council finances fundamental investigations while the Department of National Health and Welfare sponsors studies in the applied field and the Defence Research Board and the Department of Veterans' Affairs deal only with their specialized problems. In the mental health field it becomes even more difficult to distinguish fundamental from applied research than in other medical areas, however. Consequently, a high degree of flexibility is maintained in screening applications. For example, the implications of "A Clinico-Pathological Study of Dementia in Older People", sponsored by the Department of Veterans' Affairs, are not limited to veterans; the findings of an investigation of the "Correlation of Emotional and Fatigue States with Adrenocortical Activity", sponsored by the Defence Research Board, are not unique to defence interests, and an investigation of "Biochemical Changes in Cerebro-Spinal Fluid in Schizophrenia", financed by the Department of National Health and Welfare, may be just as readily classified "fundamental" as "applied" research.

Investigations in progress cover a wide range of topics, explored by a number of disciplines: biochemical, genetic, psychiatric, gerontological and others. It is impossible to discuss these projects within the scope of this monograph.

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(1) Under a Health Grant, the term "project" is used to indicate approval of a submission for one year, and is not synonymous with the term "project" as used to indicate a completed study, regardless of the time element.

TABLE XVIII. RESEARCH PROJECTS FINANCED THROUGH MENTAL HEALTH GRANT: BY SPONSORING AGENCY AND YEAR

Sponsoring Agency	1948-1949	1949-1950	1950-1951	1951-1952	1952-1953	Total to end of 1952 - 1953	Total No. Projects
Newfoundland							
Hospital for Nervous + Mental Diseases		x	x	x		1 cont. project)	1
Prince Edward Island							
Nova Scotia							
Dept. of Health			x	x	x	1 cont. project)	1
New Brunswick							
(1) Provincial Hospital	x	x				1 cont. project)	
				x	x	1 cont. project)	
(2) Psychiatric Services						)	3
Division				x	x	1 cont. project)	
Quebec							
(1) Montreal Neurological							
Institute			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
(2) McGill University							
Dept. of Psychiatry			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	11
				x	x	1 cont. project)	
					x	1 project)	
Dept. of Genetics					x	1 project)	
(3) St. Jean de Dieu						)	
Hospital			x	x	x	1 cont. project)	
Manitoba							
(1) Brandon Mental							
Hospital		x	x			1 cont. project)	
		x	x	x		1 cont. project)	3
(2) Children's Hosp-				x	x	1 cont. project)	
ital, Winnipeg.							
Saskatchewan							
Psychiatric Services							
Division					x	1 project.)	1
Alberta							
British Columbia							
University of British							
Columbia			x	x	x	1 cont. project)	1

Page 1: Total Number of Projects = 21

Sponsoring Agency	1948-1949	1949-1950	1950-1951	1951-1952	1952-1953	Total to end of 1952 - 1953	Total No. Projects
Ontario							
(1) University of Toronto							
Dept. of Psychiatry			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
			x	x	x	1 cont. project)	
				x	x	1 cont. project)	
				x	x	1 cont. project)	
				x	x	1 cont. project)	
				x	x	1 cont. project)	
				x	x	1 cont. project)	
					x	1 project)	
School of Hygiene			x	x	x	1 cont. project)	
School of Social Wk.			x	x	x	1 cont. project)	
Dept. of Psychology			x	x	x	1 cont. project)	
Institute of Child Study				x	x	1 cont. project)	27
(2) University of Western Ontario							
Dept. of Biochemistry		x	x	x	x	1 cont. project)	
Dept. of Physiology		x	x	x	x	1 cont. project)	
Dept. of Neuropathology		x	x	x	x	1 cont. project)	
Dept. of Anatomy			x	x	x	1 cont. project)	
Dept. of Preventive	x	x	x	x	x	1 cont. project)	
Medicine-Psychiatry		x	x	x	x	1 cont. project)	
Dept. of Psychology				x		1 project)	
(3) Queen's University							
Dept. of Medicine		x				1 project)	
		x	x	x		1 cont. project)	
		x	x	x		1 cont. project)	
			x	x		1 cont. project)	
(4) Ottawa University							
Dept. of Psychology		x	x	x		1 cont. project)	
(5) Alcoholism Research Foundation				x	x	1 cont. project)	
				Page 2; Total No. projects -			27
				Canada: Total No. projects -			48

Source of data: Dept. of National Health and Welfare, Mental Health Division "Research Projects under the Mental Health Grant". Ottawa: July, 1953.

FINANCING MENTAL HEALTH

THE COST OF CARING FOR THE MENTALLY ILL

The cost of maintaining patients in Canadian mental institutions in the fiscal year 1952-53 was over $60,000,000.(1) As shown in Table XIX between 1948-49 and 1951-53 expenditures by mental institutions rose from $34,879,000 to $59,925,000, an increase of over 70 percent. Part of this increase was due to more comprehensive reporting of mental institutions, but more important, were the increases in the number of patients hospitalized, improvements in treatment services and the general rise in the price level. In 1953, the cost of caring for the mentally ill was the heaviest burden which the provincial governments had to bear in providing health services.

The greater part of the cost of hospitalization is met from the general tax revenues of various governments. In most provinces, patients who are not medically indigent, are expected to pay for their care and about 12 per cent of total revenue of mental institutions is received from this source.(2) The proportion of revenue received on behalf of paying patients varies from province to province; in 1952-53, 3.1 per cent of total revenue was received on behalf of paying patients in Newfoundland, while in Prince Edward Island the proportion was 21.3 per cent.(3)

Provincial governments are the major source of revenue for mental institutions. Approximately 80 per cent of total receipts come from this source and, except in Nova Scotia, only a very small proportion is provided by federal and municipal governments.(4) However, the federal government indirectly provides revenue to institutions through the National Health Program; in 1952-53 this amounted to $4,546,000.

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(1) See Table XIX. This amount is based on expenditures of 65 of the 75 mental institutions reporting expenditures for maintenance. It does not include expenditures for mental patients in federal hospitals, psychiatric patients in general hospitals and patients in some municipal and private institutions. See D.B.S., Mental Institutions, 1952, p. 8.

(2) See Table XX.

(3) See Tables XXI and XXII.

(4) See Table XXII.

TABLE XIX. INCOME AND EXPENDITURES OF MENTAL INSTITUTIONS: BY SOURCE OF INCOME AND TYPE OF EXPENDITURE, CANADA, 1948-49 TO 1952-53

Item	1948-49(1)	1949-50 (1)	1950-51	1951-52	1952-53
	$000	$000	$000	$000	$000
Income					
Provincial Sources(2)	27,431	31,322	39,542	46,013	47,558
Municipal Sources	952	796	945	1,002	994
Federal Sources	383	472	767	961	2,306
Paying Patients	4,204	4,646	4,516	5,286	7,206
Other Sources	2,089	2,140	2,354	2,658	1,919
Total Income	35,059	39,376	48,124	55,920	59,983
Expenditures					
Maintenance	32,494	36,364	43,064	47,412	51,651
Non-Maintenance	2,385	3,049	5,389	9,666	8,274
Total Expenditures	34,879	39,413	48,453	57,078	59,925

(1) Excluding Newfoundland.

(2) Includes payments made under the National Health Program.

Source: Dominion Bureau of Statistics, Mental Institutions, 1948-52, Ottawa, Queen's Printer.

TABLE XX. PERCENTAGE DISTRIBUTION OF INCOME OF MENTAL INSTITUTIONS: BY SOURCE, 1948-49 TO 1952-53

Source of Income	1948-49[1]	1949-50	1950-51	1951-52	1952-53
	%	%	%	%	%
Provincial Governments [2]	78.2	79.5	82.2	82.3	79.3
Municipal Governments	2.7	2.0	2.0	1.8	1.7
Federal Government	1.1	1.2	1.6	1.7	3.8
Paying Patients	12.0	11.8	9.4	9.5	12.0
Other Sources	6.0	5.5	4.8	4.7	3.2
	100.0	100.0	100.0	100.0	100.0

(1) Excluding Newfoundland.

(2) Includes payments made under the National Health Program.

Source: Dominion Bureau of Statistics, Mental Institutions, 1948-52, Ottawa, Queen's Printer.

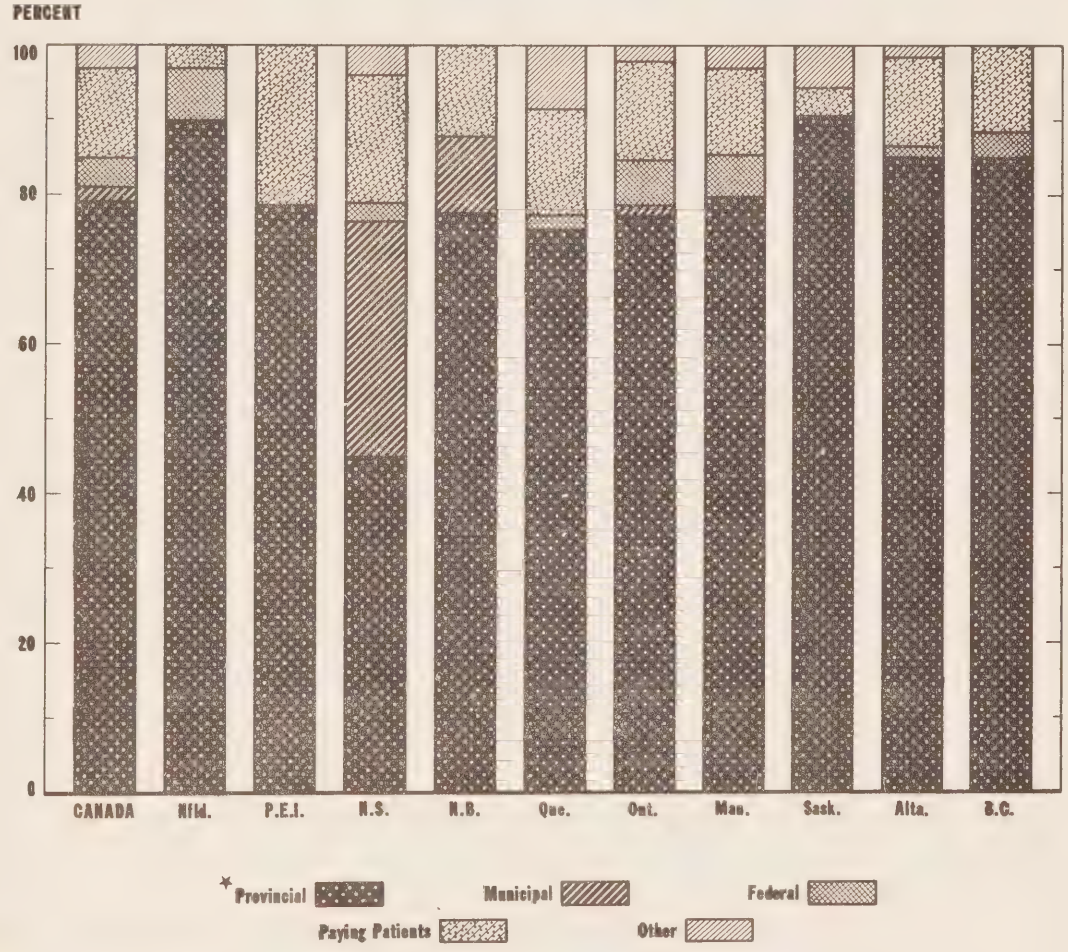
TABLE XXI. INCOME OF MENTAL INSTITUTIONS: BY SOURCE AND PROVINCE, 1952-53

Province	Federal	Provincial[1]	Municipal	Paying Patients	Other	Total
	$	$	$	$	$	$
Newfoundland	80,638	1,063,555	--	37,106	2,302	1,183,601
Prince Edward Island	--	243,428	--	65,991	--	309,419
Nova Scotia	41,603	780,655	553,986	299,947	68,442	1,744,633
New Brunswick	--	1,026,195	133,517	157,811	2,731	1,320,254
Quebec	186,462	7,712,808	500	1,443,337	855,151	10,198,258
Ontario	1,525,498	18,907,348	288,541	3,219,700	502,638	24,443,725
Manitoba	161,606	2,298,939	--	334,658	86,447	2,881,650
Saskatchewan	--	4,969,524	--	203,664	307,123	5,480,311
Alberta	76,620	4,692,393	17,156	675,950	68,834	5,530,953
British Columbia	233,324	5,863,676	--	767,787	25,455	6,890,242
Canada	2,305,751	47,558,521	993,700	7,205,951	1,919,123	59,983,046

(1) Includes payments under the National Health Program.

Source: Dominion Bureau of Statistics, Mental Institutions, 1952, Ottawa: Queen's Printer, 1953.

PERCENTAGE DISTRIBUTION OF INCOME OF MENTAL INSTITUTIONS, BY SOURCE AND PROVINCE, 1952-53



* Includes Payments made to institutions under the National Health Program

Source: Research Division, Dept. of Nat. Health & Welfare

TABLE XXII. PERCENTAGE DISTRIBUTION OF INCOME OF MENTAL INSTITUTIONS: BY SOURCE AND PROVINCE, 1952-53

Province	Federal	Provincial[1]	Municipal	Paying Patients	Other	Total
	%	%	%	%	%	%
Newfoundland	6.8	89.9	- -	3.1	.2	100.0
Prince Edward Island	- -	78.7	- -	21.3	--	100.0
Nova Scotia	2.4	44.8	31.7	17.2	3.9	100.0
New Brunswick	- -	77.7	10.0	12.0	.2	100.0
Quebec	1.8	75.6	- -	14.2	8.4	100.0
Ontario	6.2	77.3	1.2	13.2	2.1	100.0
Manitoba	5.6	79.8	- -	11.6	3.0	100.0
Saskatchewan	- -	90.7	- -	3.7	5.6	100.0
Alberta	1.4	84.8	.3	12.2	1.3	100.0
British Columbia	3.4	85.1	- -	11.1	.4	100.0
Canada	3.8	79.3	1.7	12.0	3.2	100.0

(1) Includes payments made under the National Health Program.

Source: Dominion Bureau of Statistics, Mental Institutions, 1952, Ottawa: Queen's Printer, 1953.

The national average for maintenance expenditures per patient day in 1952-53 was $2.55 having risen from $1.77 in 1948-49.(1) Individual provinces vary considerably from this average but only three provinces reported expenditures lower than the national average;(2) Newfoundland with $4.29 per day was the highest.

Newfoundland

The major part of the cost of treating the mentally ill in this province is borne by the provincial government. The government charges a fixed per diem rate for all patients in the Provincial Hospital for Mental and Nervous Diseases who are a Federal responsibility. Old age pensioners, a responsibility of the provincial Department of Welfare, pay an all-inclusive rate of $1.00 per day.

There are other patients whose relatives in the past agreed to pay varying amounts per month towards the cost of their maintenance and treatment. However, a departmental board has been established which hopes to assess each case and decide how much should be charged for the care and maintenance of the individual patient. Although the principle of partial payment has been established the assessment board had not begun to function fully in 1954.

Treatment in out-patient departments is free to all who attend and no charge is made for children assisted by Newfoundland's consultant services.

Prince Edward Island

All patients in the provincial mental hospital are charged for medical care and maintenance when they are able to pay. The rate of payment in 1954 was $50.00 per month. If a financial investigation shows that a patient is medically indigent the provincial government pays the cost. Patients, who are the responsibility of the Federal Government, are charged a per diem rate. No charge is made for any psychiatric clinical services.

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(1) See Table XXIII.

(2) See Table XXIV. This average is based on expenditures of 48 out of 75 mental institutions reporting to the Bureau of Statistics. However, these institutions provide care for over 85 per cent of mental patients.

TABLE XXIII. MAINTENANCE EXPENDITURES OF MENTAL INSTITUTIONS PER PATIENT DAY: CANADA, 1948-49 TO 1952-53

Fiscal Year	Maintenance Expenditures	
	Total	Per Patient Day
	$000	$
1948-49	32,494	1.77
1949-50	36,364	1.94
1950-51	43,064	2.23
1951-52	47,412	2.40
1952-53	51,651	2.55

Source: Dominion Bureau of Statistics, Mental Institutions, 1947 to 1952.

TABLE XXIV. MAINTENANCE EXPENDITURES FOR MENTAL INSTITUTIONS PER PATIENT DAY: BY PROVINCE, 1952-53

Province	Maintenance Expenditures	
	Total	Per Patient Day
	$	$
Newfoundland	1,167,318	4.29
Prince Edward Island	309,419	2.79
Nova Scotia	1,874,407	4.05
New Brunswick	1,307,556	2.15
Quebec	9,532,655	1.66
Ontario	19,359,125	2.23(1)
Manitoba	2,716,118	2.23
Saskatchewan	4,845,048	2.89
Alberta	3,809,934	2.74
British Columbia	6,729,475	3.82
Canada	51,651,055	2.55

(1) Based on Ontario Public Accounts, 1952-53

Source: Dominion Bureau of Statistics, Mental Institutions, 1952.

Nova Scotia

Free care is provided for all patients on active treatment in the Nova Scotia Hospital. Patients, not responding to active treatment, are transferred to municipal or county hospitals. If a municipality refuses to take the patient a charge of $3.00 a day is made to the municipality.

Municipal institutions usually charge relatives for cost of maintenance, if the relative can pay and the municipality provides the remainder of the revenue. Where a municipality has no institution it usually boards patients in another municipal institution paying a per patient, per diem rate.

The Nova Scotia Training School, operated by the province, charges the municipalities a flat rate of $350.00 a year for each patient, the provincial government pays the balance. In a few instances parents are charged small amounts, based on ability to pay.

In-patient treatment in the Psychiatric Service at the Victoria General Hospital, Halifax, is paid for at the same rate as other private or public patients. The out-patient department of this hospital charges a small fee based on ability to pay; in any case it does not exceed fifty cents a visit. All other out-patient department and clinical services, including the Child Guidance Clinic at Halifax, are free.

New Brunswick

Patients, whose relatives can afford to pay for their maintenance, are charged for their care and treatment. On March 31, 1953 there were 1647 patients in residence of whom 389 were paying patients. All but 31 of the 1258 non-paying patients were classed as municipal patients. The municipality of the patient's residence in 1953 contributed $2.00 per patient per week, and the remainder was paid by the Province.

Electroshock treatment, when given by a government physician is provided, without cost, to both in-patients and out-patients in the Moncton General Hospital. Other psychiatric services may be provided without cost by a government physician to patients of the hospital. No charge is made for the services of the provincial mental health clinics.

Quebec

Patients in mental and psychiatric hospitals who are not medically indigent are expected to pay part of the cost of maintenance and treatment in mental hospitals. The remainder of the cost of such care plus the cost of treating the medically indigent is borne by the provincial government; municipalities do not bear any of the cost. No charge is made for children in hospitals or schools for mental defectives, nor is any charge made for the services of hospital out-patient departments or community mental health clinics.

Ontario

The province of Ontario collects a modest payment for maintenance from patients who are able to pay. The minimum rate is fixed by regulation at $7.00 per week, except in the case of the Ontario Hospitals at Whitby and Woodstock, where the rate is $10.50 a week. In many cases the full rate is not collected.

Municipalities contribute to the maintenance of municipal residents who are patients in mental hospitals. The sum of ten cents per patient per day is deducted from the municipalities' share of the railway tax. Toronto and the Township of York pay $1.50 a day for the maintenance of indigent patients in the Toronto Psychiatric Hospital, this payment cannot exceed 10 days. The remainder of the cost of maintaining the Ontario (mental) Hospitals and the Toronto Psychiatric Hospital is met by the Province from general revenues.

Manitoba

The provincial government collects maintenance costs from patients in mental hospitals who can afford them. No charge is made for the care of mental defectives except where the patient has an estate in his own right. The provincial government meets the remainder of the costs of operating mental institutions from the general tax revenues. In 1953, the Manitoba government was expending six dollars on mental institutions for every one dollar of revenue.

Treatment is free at all out-patient departments in general hospitals. Only a nominal fee is charged to patients who can pay at the daily clinics of the Winnipeg Psychopathic Hospital. Similarly, a $5.00 fee is charged for electroshock treatment to those who can pay. For all practical purposes, treatment is offered free.

Saskatchewan

Complete free care is provided to all persons who are residents and have been residents of Saskatchewan for a period of at least twelve months immediately prior to admission to an institution. Admission to the psychiatric wing of the Regina General Hospital is on the same basis as admission to any ward in a general hospital; hospitalization is covered by the Saskatchewan Hospital Services Plan. Mentally defective persons are provided with care and treatment in the Saskatchewan Training School on the same basis as patients in mental institutions. Patients, in both types of institutions, not covered by the above regulations must meet their own costs. No charge is made for any of the clinical services in the province.

Alberta

In Alberta, patients in mental hospitals are charged $1.00 a day, the remainder of the cost being met from general tax revenues. Institutionalized Mental Defectives are charged at the rate of $15.00 per month, whether in Schools for Defectives or in Mental Hospitals. Where patients are hospitalized in Psychiatric Units in General Hospitals, the provincial government contributes a total amount of $7.70 per day, per patient. The provincial Child Guidance Clinics provide free service to children examined.

British Columbia

Patients in British Columbia mental institutions are expected to pay, if they are able to do so, up to a maximum of a $1.50 per day. A charge is also made for patients who are the responsibility of the Federal Government. No charge is made to the municipalities, the Provincial Government therefore, assumes the major portion of the cost of providing care and treatment for the mentally ill. There is no charge made for the services of the out-patient clinics of the Provincial Institutions or the Child Guidance Clinics.

THE NATIONAL HEALTH PROGRAM: MENTAL HEALTH

The provinces have always provided most of the treatment services for the mentally ill in Canada and the greater part of the cost of such treatment has been met from general provincial revenues. Federal grants-in-aid for provincial programs of mental health have

resulted, however, in an expansion and improvement of preventive, diagnostic, and treatment services.(1)

The federal Mental Health Grant, first made in May, 1948, was the second largest single health grant made to the provinces, being surpassed only by the general public health grant. Initially, $4,000,000 was made available to the provinces with biennial increases designed to bring the grant to $7,234,860 by 1954-55.(2) The grant was distributed on the basis of $25,000 to each province, the remainder being allocated on the basis of population. In 1953-54 the amount available to the provinces was $6,203,652 distributed in the same manner.

During the five fiscal years, 1948-49 to 1952-53, over $24,000,000 was made available to the provinces of which approximately $13,000,000 (52.7 per cent) was actually expended.(3) The rate of utilization in the earlier years was much lower than in 1952-53 owing to organizational problems and shortages of qualified personnel and equipment. Quebec did not utilize the grant until 1949-50 and no other province expended more than 43 per cent in 1948-49. In 1952-53, 73 per cent of the total grant was utilized varying from 89 per cent and 83 per cent in Saskatchewan and Quebec respectively to 45 per cent in Nova Scotia.

For the whole of Canada nearly half the grant was used to expand and develop services in mental institutions including psychiatric, psychological, special nursing and rehabilitation services. In addition, substantial amounts of equipment were supplied.(4)

The development of community short-term treatment centres and diagnostic clinics has also received an impetus from the National Health Program. Approximately 20 per cent of the grants have been devoted to the organization of psychiatric services in general hospitals and mental health clinics. Mental health education and the administration of provincial mental health programs utilized 3.8 per cent, research 6.9 per cent and personnel training 20 per cent.(5)

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(1) See National Health Program - Five Year Report, Department of National Health and Welfare, Ottawa, 1953, pp. 44-48.

(2) Originally the grant was to have reached $7,000,000 by 1954-55. However, the provision of funds for Newfoundland, the Yukon and the Northwest Territories has raised the amount available for expenditure to $7,234,860.

(3) See Table XXV.
(4) See Table XXVI.
(5) See Table XXVI.

TABLE XXV. FEDERAL MENTAL HEALTH GRANT, AMOUNTS AVAILABLE, EXPENDITURES, AND PERCENTAGE OF AMOUNTS AVAILABLE EXPENDED: BY PROVINCE, FISCAL YEARS 1948-49 TO 1952-53

	Amount Available $	Expenditures $	Percentage Expended %
Canada	24,619,000	12,969,829	52.7
Newfoundland	602,000	362,447	60.2
Prince Edward Island	290,000	139,991	48.3
Nova Scotia	1,239,000	498,551	40.2
New Brunswick	1,012,000	510,634	50.5
Quebec	6,892,000	4,109,338	59.6
Ontario	7,800,000	3,629,983	46.5
Manitoba	1,464,000	558,715	38.2
Saskatchewan	1,606,000	1,156,978	72.0
Alberta	1,655,000	684,559	41.4
British Columbia	2,059,000	1,318,603	64.0

TABLE XXVI. PERCENTAGE DISTRIBUTION OF MENTAL HEALTH GRANT EXPENDITURES; BY TYPE OF PROGRAM, FIVE YEAR PERIOD ENDING March 31, 1953.

Province	Mental Institutions (1)	Psychiatric Units in General Hospitals (2)	Out-Patient and Community Clinics (3)	Other Mental Health Services (4)	Research	Training	Totals
	%	%	%	%	%	%	%
Newfoundland (5)	79.6	-	-	3.6	2.5	14.3	100.0
Prince Edward Island	57.4	-	21.3	4.0	-	17.3	100.0
Nova Scotia	32.7	7.7	8.6	8.6	9.9	32.5	100.0
New Brunswick	35.5	-	23.5	7.9	1.9	31.2	100.0
Quebec	36.8	18.3	15.1	2.0	6.3	21.5	100.0
Ontario	47.0	4.5	7.1	1.7	13.4	26.3	100.0
Manitoba	75.8	1.9	12.3	0.5	2.3	7.2	100.0
Saskatchewan	52.7	17.5	12.4	11.5	1.2	4.7	100.0
Alberta	71.0	1.1	19.8	0.5	-	7.6	100.0
British Columbia	67.7	1.9	2.2	8.3	4.6	15.3	100.0
Canada	48.9	9.2	11.2	3.8	6.9	20.0	100.0

(1) Staff and equipment.
(2) Some personnel and equipment of psychiatric units employed part-time in out-patient clinics.
(3) Some personnel and equipment of out-patient clinics employed part-time in in-patient treatment.
(4) Primarily for employment of personnel in provincial mental health divisions and for mental health education.
(5) Grants to Newfoundland commenced 1949-50.

Source: Research Division, National Health and Welfare.

The nature of the program carried out by each province has varied considerably. Newfoundland spent nearly 80 per cent of its grant for aid to mental institutions while Nova Scotia and New Brunswick spent less than 36 per cent. New Brunswick allocated 23.5 per cent of its grant to out-patient and community clinics while British Columbia used only 2.2 per cent for these services. However, as the more pressing needs of hospitals for equipment are met a larger part of the grant will become available for other services.

In addition to expenditures under the Mental Health Grant a substantial amount has been made available to the provinces to assist in the construction of mental hospitals and psychiatric units in general hospitals. From April 1, 1948 to March 30, 1953, over $8,000,000 was expended for this purpose.(1) The grant is allocated to the provinces on the basis of $1,500 per bed in mental institutions; the province must match or exceed the federal contribution which in no case exceeds one-third of the total cost.

(1) See Table XXVII. For extent of accommodation provided under the National Health Program see pp. 42-55.

TABLE XXVII. FEDERAL GRANTS TO PROVINCIAL GOVERNMENTS FOR THE CONSTRUCTION OF ACCOMMODATION FOR MENTALLY ILL AND DEFECTIVES: 1948-49 TO 1952-53

Province	Actual Grant Expenditures		
	Mental Institutions	General or other Hospitals(1)	Totals
Newfoundland	332,181	-	332,181
P.E.I.	-	-	-
N.S.	283,511	-	283,511
N.B.	84,375	12,252	96,627
Que.	2,903,611	35,709	2,939,320
Ont.	2,610,248	67,821	2,678,069
Man.	525,211	-	525,211
Sask.	406,000	22,600	428,600
Alta.	101,936	25,084	127,020
B.C.	755,229	-	755,229
Canada	8,002,302	163,466	8,165,768

(1) Estimate only; excludes estimated expenditures on beds other than mental, in general hospitals.

Source: Research Division, Department of National Health and Welfare, 1954.

FUTURE OBJECTIVES[1]

This monograph "Mental Health Services in Canada" has presented an account of mental health facilities and programs as factually and objectively as possible on the basis of available data. It begins with a historical sketch of the early development of mental health services and discusses the contemporary situation and current trends which give some indication of what may be expected in the future.

It can readily be seen from the historical review that the first forward step occurred early in the nineteenth century when it became recognized that the "insane" require humane care rather than institutionalization to protect the community. This new emphasis on humane care led to the development of separate institutions but these institutions were operated by various government departments such as Agriculture or Public Works, for care of the "insane" was not yet recognized as a concern of health authorities.

Visits to the older "asylums" leave an impression that the original designs of the buildings were quite adequate and, in particular, a considerable amount of day and recreation space was provided. Gradually, however, the demand for hospitalization increased and hospital construction failed to keep pace with it. Accordingly, more and more beds were set up in the auxiliary space, with a consequent loss of the facilities which were so essential in the treatment of patients.

As "insanity" became recognized as an illness, health authorities gradually assumed responsibility for the care of persons suffering from this disease. This change appears to have been made with the following objectives:

a. Establishment of a medical treatment program
b. Raising of hospital standards
c. Co-ordination with other health services

In the pursuit of these aims, progress has been made in varying degree. The size of the problem has frequently baffled authorities and mitigated progress; however, to meet this problem provincial health departments have established mental health divisions responsible for the following services:

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(1) Based on interpretations by Dr. C.A. Roberts, Chief, Mental Health Division, Department of National Health and Welfare.

a. Development of a hospital program as large but not as active or as costly as that of general hospitals
b. Development of training programs
c. Organization of programs of public education in mental health
d. Research

It is impossible to predict what steps will be taken to improve mental health services, either in the immediate or more distant future. On re-examining the needs of the past and of the present, however, it is not too difficult to visualize five desirable future goals

The first objective is a more adequate development of the central mental health divisions. The staffs of these divisions must be qualified and sufficiently diverse to handle the variety of responsibilities placed on the division - the supervision of psychiatric units in general hospitals, the community clinics, mental hospitals, training schools, research, personnel training programs and public education.

The second objective is a further improvement of both the medical and non-medical aspects of mental hospital administration. Standards of care in the hospitals must be raised. This involves further segregation of various classes of patients and development of specialized services suited to each class. Some progress has been made in this direction but despite the increasing life span and the consequent anticipated growing demand for accommodation for seniles and other continued care cases, segregation of the aged mentally ill has barely begun. In recent years, considerable advance has been made in the construction of training schools for the mentally defective; nevertheless, space is as yet inadequate and many schools presently lack the necessary staffs to carry on an optimum training program. It is apparent, too, throughout this report that many mental defectives still receive only custodial care in the mental hospitals. Standards need to be raised not only for continued care cases but also for the acutely ill. A crucial factor in improving treatment here also is the availability of more skilled medical and non-medical personnel.

From time to time throughout this monograph, mention has been made of community mental health programs. A third desirable forward step would be the better integration of psychiatric programs with other health

services and a more widespread recognition of mental health services as community services, regardless of whether they are provided by a mental hospital or a general hsopital or a clinic.

The fourth goal is a reassessment of the training programs for mental health workers. A clarification of the roles and anticipated contributions of the various professional groups is prerequisite to any adequate review of training programs. Any planning raises the following questions: What is the real need for workers in this field? How much of this need can be financed at the present time? Are current training programs suitable in content to qualify the workers for the anticipated contribution to mental health services?

The fifth great need is for evaluation of the present research efforts. Is there a proper balance between basic or fundamental and applied research? Are the most pressing problems of the mental health services being investigated? Is there opportunity for development of research workers? The availability of funds has improved greatly as compared with a decade ago but are the funds being used to the best advantage?

In addition to these major objectives there are others based on the need to eradicate the prejudices associated with mental illness through public and school education, the need for more public participation in the activities of the hospitals, the need for research into fundamental problems basic to treatment procedures and for evaluation of the effectiveness of present therapies.

There is much to be done. However, as we look back to the hope and plans of mental health authorities a hundred or fifty or twenty-five or even five years ago, we see their dreams gradually realized. Out of these realizations arises our own hopes for the future.

APPENDIX I

LIST OF MENTAL INSTITUTIONS IN CANADA

Name and Location	Location	Class of Patient
Newfoundland		
Hospital for Mental and Nervous Diseases	St. John's	All classes
Price Edward Island		
Falconwood Hospital, Charlottetown	Charlottetown	Mentally ill
Provincial Infirmary	Charlottetown	Mental defectives, seniles and continued care cases
Nova Scotia		
Nova Scotia Hospital	Dartmouth	Mentally ill
Nova Scotia Training School	Truro	Mental defectives
Halifax City Home	Halifax	
Annapolis County Hospital	Annapolis	
Argyle Municipal Home	Argyle	
Cape Breton County Hospital	Sydney	
Clare Municipal Home	Meteghan	
Colchester County Home	Truro	
Cumberland County Home	Pugwash	

Name and Location	Location	Class of Patient
Nova Scotia (Cont'd)		
Digby County Asylum	Marshalltown	Mentally ill and mental defectives
East Hants Municipal Home	South Maitland	
Halifax County Home	Cole Harbour	
Inverness County Asylum	Mulgrave	
Kings County Hospital	Waterville	
Lunenburg County Asylum	Lunenburg	
Pictou County Asylum	Stellarton	
Queens County Asylum	Middlefield	
Shelburne County Asylum	Shelburne	
West Hants Industrial Home	Newport	
New Brunswick		
The Provincial Hospital	Lancaster	Mentally ill and mental defectives
The Provincial Hospital	Campbellton	
Quebec		
Hopital Saint-Jean-de-Dieu	Gamelin	Mentally ill
Hopital Saint-Michel-Archange	Mastai	Mentally ill

Name and Location	Location	Class of Patient
Quebec (Cont'd)		
Hopital Saint-Julien	Saint-Ferdinand	Mentally ill and Mental defectives
Hopital de Bordeaux	Montreal	Mentally ill prisoners
Retraite Saint-Benoit	Montreal	Mentally ill and defectives
Hopital Sainte-Elizabeth	Roberval	Mentally ill and defectives
Verdun Protestant Hospital	Montreal	Mentally ill and defectives
Clinique Roy-Rousseau	Mastai	Neuro-Psychiatric patients
Hopital Sainte-Anne	Baie St. Paul	Mentally ill and defectives
Institute Medico-Pedagogique Mont-Providence	Rivieres-des-Prairies	Mental defectives
La Societe de Rehabilitation	Sherbrooke	Mental defectives
Sanatorium Prevost	Montreal	Psychiatric patients
Allen Memorial Institute	Montreal	Psychiatric patients
Hotel-Dieu-du-Sacre-Coeur de Jesus	Quebec	Epileptics

Name and Location	Location	Class of Patient
Quebec (Cont'd)		
Les Etablissement Notre-Dame	Saint-Charles-Sur-Richelieu	Epileptics
Dieppe House	Saint-Hilaire	Epileptics
Sainte-Anne's Hospital	Sainte-Anne-de-Bellevue	Veterans
Ontario		
The Ontario Hospital	Brockville	Mentally ill
The Ontario Hospital	Cobourg	Continued care cases
The Ontario Hospital	Port Arthur	Continued care cases
The Ontario Hospital	Hamilton	Mentally ill
The Ontario Hospital	Kingston	Mentally ill
The Ontario Hospital	Langstaff	Continued care cases
The Ontario Hospital	London	Mentally ill
The Ontario Hospital	New Toronto	Mentally ill
The Ontario Hospital	Penetanguishene	Mentally ill and mentally ill prisoners

Name and Location	Location	Class of Patient
Ontario (Cont'd)		
The Ontario Hospital	St. Thomas	Mentally ill
The Ontario Hospital	Toronto	Mentally ill
The Ontario Hospital	Whitby	Mentally ill
The Ontario Hospital	Woodstock	Epileptics and tuberculous cases
The Ontario Hospital	Aurora	Adult mental defectives
The Ontario Hospital School	Orillia	Mental defectives
The Ontario Hospital School	Smiths Falls	Mental defectives
Toronto Psychiatric Hospital	Toronto	Psychiatric patients
The Homewood Sanitarium (Private)	Guelph	Mentally ill
Bethesda Home for the Mentally Ill (Private)	Vineland	Mentally ill
Westminister Hospital (Federal)	London	Veterans
The Bell Clinic (Private)	Toronto	Alcoholics
Manitoba		
Hospital for Mental Diseases	Brandon	Mentally ill
Hospital for Mental Diseases	Selkirk	Mentally ill

Name and Location	Location	Class of Patient
Manitoba (Cont'd)		
Winnipeg Psychopathic Hospital	Winnipeg	Psychiatric patients
The Manitoba School for Mentally Defective Persons	Portage la Prairie	Mental defectives
Saskatchewan		
The Saskatchewan Hospital	North Battleford	Mentally ill
The Saskatchewan Hospital	Weyburn	Mentally ill
Munroe Wing, Regina General Hospital	Regina	Psychiatric patients
The Saskatchewan Training School	Weyburn	Mental defectives
Alberta		
The Provincial Hospital	Ponoka	Mentally ill
The Provincial Mental Institute	Edmonton	Mentally ill
The Provincial Auxiliary Mental Hospital	Raymond	Continued care cases
The Provincial Auxiliary Mental Hospital	Claresholm	Continued care cases

Name and Location	Location	Class of Patient
Alberta (Cont'd)		
Provincial Training School	Red Deer	Mental defectives
"Rosehaven" (Home for the Aged)	Camrose	Seniles
British Columbia		
Provincial Mental Hospital	Essondale	Mentally ill
Crease Clinic	Essondale	Psychiatric patients
The Woodlands School	New Westminister	Mental defectives
The Provincial Mental Home	Colquitz	Mentally ill prisoners
Provincial Home for the Aged	Port Coquitlam	Seniles
Provincial Home for the Aged	Vernon	Seniles
Provincial Home for the Aged	Terrace	Seniles
The Hollywood Sanatorium (Private)	New Westminster	Mentally ill

APPENDIX II

LIST OF HOSPITALS AND OTHER ORGANIZATIONS PROVIDING CLINICAL SERVICES TO OUT-PATIENTS IN QUEBEC

I. CLINICS SERVING THE MONTREAL AREA AND WESTERN QUEBEC

A1. Hospital clinics, directed by University of Montreal

Hotel-Dieu-de-Montreal(G)
(Neuro-psychiatric clinic)

Hopital Notre-Dame(G)
(Neuro-psychiatric clinic)

Hopital General de la Misericorde(Ma)

St. Mary's Hospital(G)

Hopital Saint-Justine(C)

Hopital Saint-Luc(G)

Hopital Maisonneuve(G)

Sanatorium Prevost(P)

Hopital General Saint Vincent de Paul,(G)
Sherbrooke

Hopital General de Verdun(G)

Hopital du Sacre-Coeur(TB)

Sanatorium Saint-Joseph de Rosemont(TB)

A2. Hospital clinics directed by McGill University

Royal Victoria Hospital(G)

Montreal General Hospital(G)

Children's Memorial Hospital(C)

Jewish General Hospital(G)

Royal Edward Laurentian Hospital(TB)

Verdun Protestant Hospital(M)

B. Clinics not Directed by a University

Hopital Sainte-Jeanne d'Arc(G)

C. Non-Hospital Clinics Affiliated with Universities

Centre d'Orientation

Mental Hygiene Insititute
(a) Montreal Clinic, Pine Avenue
(b) Travelling clinics to Shawbridge and St. Bruno

D. City of Montreal

Division of Child Hygiene, Mental Health Section - operates clinics for referred school children, both French and English.

II. CLINICS SERVING QUEBEC CITY AREA AND EASTERN QUEBEC

A. Hospital clinics directed by Laval University

Quebec City

Hotel-Dieu (G)

Hopital du Saint Sacrement (G)

Hopital Saint Francois d'Assise (G)

Hopital de l'Enfant-Jesus (G)

Jeffery Hale Hospital (G)

Province

Hotel-Dieu Saint-Vallier, Chicoutimi (G)

Hotel-Dieu, Levis (G)

Other

Non-Hospital Clinics

B. Directed by Laval University	C. Other
Psychiatric Nursing Service (a) Sanatorium Ross(TB) (b) Sanitary Unit Gaspe(HU)	Medico-Social Institute of Three Rivers
Family Service and Health Unit,(HU) Rimouski	
Centre Medico-Social, Quebec City	
Social Rehabilitation Centre, Quebec City	
Rehabilitation Society of Sherbrooke, Inc., Sherbrooke	

Key: C - Children's Hospital.
G - General Hospital.
M - Mental Hospital.
Ma - Maternity Hospital.
P - Psychiatric Hospital.
TB - Tuberculosis Hospital.
HU - Health Unit.

APPENDIX III

LIST OF HOSPITALS AND OTHER ORGANIZATIONS PROVIDING CLINICAL SERVICES TO OUT-PATIENTS IN ONTARIO

Out-Patient Departments

Toronto:	Toronto Psychiatric Hospital (also in-patient) Toronto General Hospital, Wellesley Division (also in-patient) Sick Children's Hospital St. Michael's Hospital Mount Sinai Hospital Our Lady of Mercy Hospital Toronto Western Hospital (also in-patient)
Ottawa:	Ottawa General Hospital (also in-patient) Ottawa Civic Hospital (also in-patient)
London:	Victoria General Hospital (also in-patient) St. Joseph's Hospital (also in-patient)
Kingston:	Kingston General Hospital
Sudbury:	Sudbury General Hospital
Kitchener:	Kitchener-Waterloo Hospital
St. Catharines:	St. Catharines General Hospital (also in-patient)
Hamilton:	Hamilton General Hospital
Peterborough:	Peterborough Civic Hospital
Ontario Hospitals:	London Hamilton Kingston Brockville St. Thomas

Stationary All-Purpose Clinics

Hamilton:	Hamilton Clinic

Stationary All-Purpose Clinics (Cont'd)

Toronto:	City Hall Clinic York Township Clinic Toronto Mental Health Clinic

Stationary Child Guidance Clinics

Windsor:	Windsor Clinic
Ottawa:	Ottawa University
Toronto:	Toronto Leaside (East York) Clinic Board of Education Clinic Sick Children's Hospital

Travelling Clinics

Ont. Hosp.(Kingston)	Kingston Belleville Perth Almonte Renfrew Pembroke
Ont. Hosp.(Hamilton)	Hamilton Guelph Wentworth Simcoe Milton Brantford Shelburne Dunnville
Ont. Hosp. (Brockville)	Brockville Ottawa Cornwall Alfred Morrisburg
Ont. Hosp.(London)	London Sarnia Woodstock Chatham Windsor Stratford Owen Sound

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